PUBLIC HEALTH NURSING

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1944

■ TREATMENT OF POLIO
JESSIE WRIGHT, M.D.

■ CENSUS OF PUBLIC HEALTH NURSES
PEARL McIVER

■ VENEREAL DISEASE IN INDUSTRY
PERCY SHOSTAC

■ GUIDANCE FOR INDUSTRIAL NURSES
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PUBLIC HEALTH NURSING

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Planning Committee Defines Objectives

A FIVE-YEAR blueprint for a better nursed and healthier America is being developed by the National Nursing Planning Committee of the National Nursing Council for War Service, which met September 12 to define objectives and areas of action.

Under the chairmanship of Marion W. Sheahan, president of the NOPHN, and with a membership including representatives of the national nursing organizations and the federal nursing services, the committee is at work not only on postwar but on immediate problems leading into the postwar era. Marjorie B. Davis, chairman of the Massachusetts Nursing Council for War Service, and widely experienced in various fields of nursing, has joined the Council staff as secretary of the committee.

The following objectives were approved in principle by the National Nursing Council on September 16 on the premise that the purpose of the nursing profession is to plan and promote a program "to provide and maintain nursing services at a high level of competence to meet the needs of all the people in sickness and health."

1. Determine the needs of the nation for nursing care.

2. Determine the number of nurses required to meet immediate needs for all types of nursing care.

3. Provide for meeting additional needs as social programs advance.

4. Educate nurses to give the best service made possible by current scientific knowledge.

5. Promote, develop, and adopt personnel policies and practices which will be satisfactory to employer and employee, and which provide remuneration for nurses commensurate with the services rendered to society.

6. Promote and support plans which will assure nursing care for all in need of it, through an equitable distribution of the service cost.

7. Promote, develop, and establish standards to guard the public and the nurse.

8. Help the public understand to what extent nursing contributes toward healing the sick and promoting positive health, to the end that comprehensive community programs may be developed and supported.

9. Maintain a progressive program of information directed to nurses to help them understand and accept their responsibilities and opportunities.

10. Support the above programs without regard to race, creed, color, economic status, or geographical location.

Members of the committee include:

National Nursing Council for War Services—Stella Goostray, Mrs. Elmira B. Wickenden

American Nurses' Association—Katharine J. Densford, Mrs. Alma H. Scott, Mrs. Henrietta Adams Loughran

National League of Nursing Education—Ruth Sleeper, Adelaide Mayo, Anna D. Wolf

National Organization for Public Health Nursing—Marion W. Sheahan, Ruth Houlton

National Association of Colored Graduate Nurses—Mrs. Frances F. Gaines, Mrs. Mabel K. Staupers, Mrs. Henrietta Farrar

Association of Collegiate Schools of Nursing—Mrs. Elizabeth Soule, Mrs. Dorothy R. Williams

American Red Cross—Virginia Dunbar

National Association of Practical Nurse Education—Hilda Torrop

Council of Federal Nursing Services—Pearl McIver

U. S. Public Health Service, Division of Nurse Education—Lucile Petry

Procurement and Assignment Service—L. Louise Baker

The 1944 Census of Public Health Nurses

By PEARL McIVER, R.N.

COPIES OF the tabulations of the 1944 census of public health nurses are now available through the United States Public Health Service. These data are collected by the respective state health departments as of January first of each year and submitted to the Public Health Service through its district offices.

The 1944 tabulations include data from every state (except New Jersey), from the District of Columbia, the territories of Hawaii and Alaska and the insular possessions of Puerto Rico and the Virgin Islands.

NUMBER OF PUBLIC HEALTH NURSES

A first glance at the final figures as presented in Table I would seem to indicate a decrease in the total number of public health nurses on duty January 1, 1944. However, New Jersey (which employed 1142 nurses in 1943) is not included in the 1944 table. The Virgin Islands have been included for the first time. If it may be assumed that New Jersey had approximately as many nurses in 1944 as in 1943, there was a slight increase in the number of public health nurses in Continental United States this year.

For the past seven years certain trends have been evident. These trends may be summarized as follows:

1. There has been a continuous growth in the number of nurses employed by rural official agencies until 1944. The 1937 tabulations showed that 1969 nurses were employed by rural official agencies; in 1943 there were 4946 (exclusive of those employed in Puerto Rico and the Virgin Islands). There were actually more

TABLE I. PUBLIC HEALTH NURSES EMPLOYED IN THE UNITED STATES, HAWAII, ALASKA, PUERTO RICO AND THE VIRGIN ISLANDS[1] ON JANUARY FIRST OF THE YEARS 1940, 1941, 1942, 1943, 1944

	Number of nurses employed in				
	1940	1941	1942	1943	1944
Total Public Health Nurses[2]	20,434	20,441	21,123	20,772	19,821[1]
State Agencies	840	859	864	886	811
Local Official Health Agencies—Rural	4,399	4,377	4,971	5,127	4,900
Urban	5,301	5,259	5,640	5,604	5,443
Local Boards of Education	3,952	4,010	3,913	3,786	3,722
Local Nonofficial Agencies	5,820	5,803	5,590	5,156	4,713
National Agencies and Universities	122	133	145	213[3]	232[3]
Number of counties having no rural public health nursing service	857	679	782	826	845
Number of cities having no public health nursing of any type	20	31	32	28	13

[1] Puerto Rico included in 1942, 1943, and 1944 totals only; Virgin Islands included in 1944 totals only. No report received from New Jersey in 1944. (The 1943 total for New Jersey was 1142.)

[2] Exclusive of industrial nurses.

[3] A considerable number of nurses employed by the American Red Cross are engaged in activities that are not strictly public health nursing.

TABLE II. STAFF PUBLIC HEALTH NURSES AND SUPERVISORS, JANUARY 1, 1940 AND 1944, IN THE UNITED STATES, HAWAII AND ALASKA

	Staff Public Health Nurses		Supervising Public Health Nurses	
	1940[1]	1944[2]	1940[1]	1944[2]
Total	18,547	18,476	1,765	2,017
State agencies	438	452	402	403
Rural official agencies	4,163	4,561	236	335
Urban official agencies	4,917	5,019	384	501
Boards of education	3,876	4,053	76	88
Nonofficial agencies	5,153	4,391	667	690

[1] 1941 data used for California.
[2] 1943 data used for New Jersey.

nurses employed by rural health departments in 1944 than in 1943. The reduction was in the number of nurses who were not connected with an organized health department but were employed directly by county governments.

2. There has been a gradual reduction in the number of nurses employed by nonofficial health agencies since 1939. There were 5963 nurses in nonofficial agencies in 1939 and 5081 in 1944, if the 1943 figures for New Jersey are added.

3. The number of nurses employed by boards of education has fluctuated from year to year, but the 1939 and 1944 figures were practically the same. In 1939 there were 4120 nurses employed by boards of education and in 1944 (through the addition of the 1943 figures for New Jersey), the total number was 4144.

4. While the number of cities (having a population of 10,000 or more) with no public health nursing service decreased greatly in 1944 compared with 1942 and 1943, the number of counties which had no nursing service increased. Eight hundred forty-five counties (more than one fourth of all the counties in the United States) had no public health nursing service of any type on January 1, 1944.

5. Even though 1943 data for New Jersey are added to the 1944 material, it will be seen from Table II that there has been a slight reduction in the number of public health nurses on the staff level. Using the November 1943 estimated population for each state, it was found that the average population per staff nurse was more than 5000 in 39 states and less than 5000 in 9 states and the District of Columbia. The Public Health Committee of the Procurement and Assignment Service and the Administrative Practice Committee of the American Public Health Association recommended that there be at least 1 public health staff nurse to each 5000 of the population. No state has reached the ratio of 1 nurse to 2000 population, which for many years has been recommended by the National Organization for Public Health Nursing. Some of the New England States, which have ratios of 1 to 3000 or 4000, come the nearest to this ratio. If each state were to have the minimum ratio of 1 nurse to 5000 population, about 8000 additional staff nurses would be needed right now.

6. The number of nurses holding supervisory positions increased appreciably in 1944. These data do not separate supervisors, administrators and special consultants; so it is difficult to compute satisfactory ratios. The American Public Health Association Subcommittee on Local Health Services recommends 1 full-time supervisor for every 10 staff nurses. But that ratio does not provide for additional administrative personnel in large health agencies, for state supervisors, nor for special consultant nurses. Since the 1944 total of 2017 supervisors includes all of these groups, an estimate of 1 supervisor to 9 staff nurses may be regarded as a minimum ratio. On that basis, 19 states had less than the minimum number of supervisors, five had a ratio of 1 to 9, and

24 states and the District of Columbia had more supervisors than the minimum ratio of 1 to 9. Rural official agencies and nonofficial agencies had the greatest increase in the number of supervisors reported in 1944. If each state were to reach a minimum of at least 1 staff nurse to 5000 population and 1 supervisor to 9 staff nurses, more than 900 additional supervisors would be needed. At present, the number of staff nurses per supervisor ranges from 1 to 21 in one state to 1 to 5 in two states.

QUALIFICATIONS OF PUBLIC HEALTH NURSES

Many qualified public health nurses have gone into military service; qualified replacements have not been available; and some of the vacancies have had to be filled by nurses with no public health preparation. The percentage of staff nurses in rural official agencies who had no formal preparation for public health nursing was 29.4 in 1940 and by 1944 it had increased to 34.8. However, while more nurses with no formal university training for public health work were employed in public health work in 1944, the percentage (29.2) of nurses who had completed one or more years of public health training was slightly higher than it has ever been. In 1940, the first year for which data on the qualifications of public health nurses are available, the percentage of nurses who had completed one or more academic years of public health preparation was 22.4. Table III gives the percentage of staff nurses who had completed one or more years of public health study and those with academic degrees in 1944 as compared with 1940.

The 1944 data reveal an improvement in the qualifications of supervisors which is especially significant. While it is recognized that native ability and a keen understanding of people are factors of primary importance among the qualifications of a good supervisor, it is generally accepted that at least one year of postgraduate preparation in public health nursing and an academic degree are desirable requirements. Table IV shows the improvement in these two factors since 1940 by type of agency. The percentage of rural and state supervising nurses who have completed a public health program of study and who have academic degrees is especially commendable. Eighty percent of all rural official supervisors had completed one or more years of public health nursing study and 48.4 percent of them had one or more academic degrees in 1944.

When the number and qualifications of supervisors are compared by states, several interesting facts are apparent. Three of the western states having the highest number of staff nurses per supervisor have the highest percentage of well qualified supervisors. Two states have 1 supervisor to every 5 or 6 nurses, but only a small percentage of the supervisors which they

TABLE III. EDUCATIONAL QUALIFICATIONS OF STAFF PUBLIC HEALTH NURSES IN 1940 AND 1944 IN THE UNITED STATES, ALASKA AND HAWAII

	Percent of total number in each type of agency who had completed one or more years of public health nursing study		Percent of total number in each type of agency who had one or more academic degrees	
	1940[1]	1944[2]	1940[1]	1944[2]
State agencies	14.6	28.3	6.1	8.0
Rural official agencies	28.1	32.1	10.4	12.5
Urban official agencies	12.1	18.9	3.3	5.8
Boards of education	19.1	20.0	9.8	11.1
Nonofficial agencies	16.1	20.0	8.9	9.8

[1] No 1940 data available for California, so 1941 data used for that state.
[2] No 1944 data available for New Jersey, so 1943 data used for that state.

TABLE IV. EDUCATIONAL QUALIFICATIONS OF PUBLIC HEALTH NURSING SUPERVISORS IN 1940 AND 1944 IN THE UNITED STATES, ALASKA AND HAWAII

	Percent of total number of supervisors who had completed one or more years of public health nursing study		Percent of total number of supervisors who had one or more academic degrees	
	1940[1]	1944[2]	1940[1]	1944[2]
State agencies	66.4	80.9	30.1	44.9
Rural official agencies	64.8	80.0	38.6	48.4
Urban official agencies	42.2	58.3	17.5	29.5
Boards of education	39.5	37.5	22.4	26.1
Nonofficial agencies	56.6	68.7	31.3	40.1

[1] No 1940 data available for California, so 1941 data used for that state.
[2] No 1944 data available for New Jersey, so 1943 data used for that state.

have meet the recommended qualifications. Two states (both in the East) need a greater number of supervisors and need better qualified ones also.

NEED FOR FURTHER ANALYSES

Many health authorities predict a significant expansion in public health facilities during the postwar period. If public health nursing services are to be expanded in accordance with our present public health nursing ideals, appropriating bodies will want factual information which is not now readily available. Public health and nursing administrators will be expected to have authoritative answers to such questions as:

1. How many and what type of nursing personnel must be added to the staff of a rural health department which meets the minimum standards recommended by the American Public Health Association if a complete public health nursing service, including bedside nursing care, is to be provided?

2. How much bedside nursing care should be made available to all citizens through tax funds? When does nursing care of the sick cease to be a public health asset and become a luxury or "convenience" service for limited groups of the population?

3. Can a satisfactory plan of full and part payment for nursing care on a visit basis be developed under official agency?

4. When is the point of diminishing returns reached in the follow-up of such communicable diseases as tuberculosis and the venereal diseases? Could the effectiveness of nursing service be increased if these cases were more carefully screened and preliminary visits made by nonprofessional investigators?

5. Is it necessary for every nurse who participates in the public health program to have had an approved program of study in public health nursing? Could an area be served by a team of nurses consisting of a fully prepared public health nurse who might have as assistant a senior cadet nurse; a returned veteran nurse who has not had special training or experience in public health nursing; or a competent practical nurse?

6. Could better organized group instruction reduce the amount of nursing time now spent in individual health supervision in the homes?

7. How many nursing consultants in the clinical specialties are required to insure effective nursing programs in those specialties? Could the special nursing consultants serve both hospital and health agencies within a certain area?

Data on the number and qualifications of all public health nurses will continue to be needed. But these data must be supplemented by qualitative analyses if we are to be prepared for an expanded postwar public health nursing program.

The Nurse in Industry Organizes against VD

By PERCY SHOSTAC

PART I

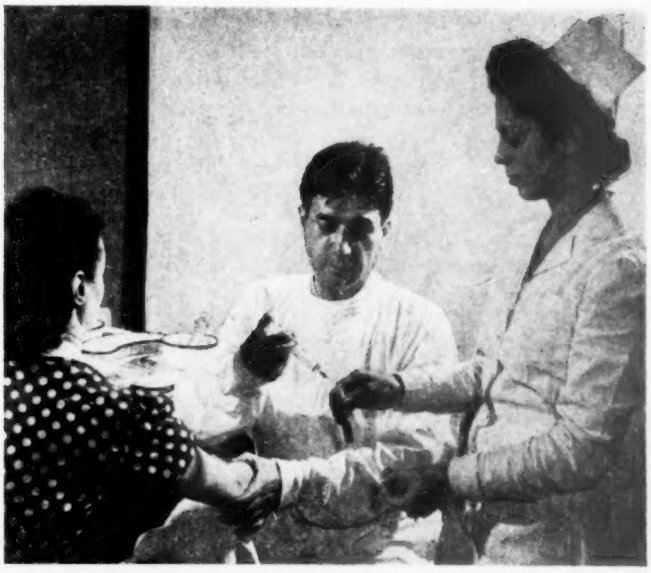
IF YOU ARE one of the twelve thousand or more nurses looking after the health needs of our industrial and office workers then take a deep breath and knock wood because you are a very fortunate person. That goes even if you have just finished one of those frightful days with your records at loose ends, your examination schedule disrupted by two nasty accidents and a young woman worker who insisted on fainting because she was six months pregnant and you didn't know it, and topped by a visit from the general manager's wife who was all eyes and ears to know how a factory dispensary functions. Yes, despite the rough days and the tough going you can thank your lucky stars that you are a member of a profession whose purpose is to bring a measure of aid and comfort and well being to the men and women who earn their bread by the sweat of their brows.

There are not many such professions. The men who serve God through the church answer a call to the ministry. Ideally the judge, the governor, even the lawyer receive their greatest compensation in the service they render. Emphatically this applies to the physician and to the nurse.

As a servant of the people you are blessed with an inexhaustible source of satisfaction in your work. You need never ask yourself, "Why am I doing this?" Aside from your weekly pay check you are privileged to serve. This is a great opportunity and a deep responsibility. If there is a physician employed by your firm he is the commanding officer on the medical front and you are his aide-de-camp. It is you who have the most intimate and direct contact with the employees; you to whom they confide their difficulties; you who must be their friend, advisor, teacher, medical leader.

In order to be an effective line officer you must know your stuff. Any doctor worthy of his degree keeps abreast in his field by reading, study, and even by occasional postgraduate work. You must do likewise. In addition to your basic knowledge of the art of nursing, you must be familiar with the last word on industrial hygiene, workmen's compensation, accident prevention and safety promotion, plant sanitation, industrial welfare activities and personnel administration, nutrition, communicable disease control and mental hygiene. You must know the medical and welfare resources of your community; the hospitals, clinics, health and welfare agencies and public health facilities. You must visit these places, and become acquainted with their intake workers so that you can make effective referrals in cases of need among your charges. You must read, you must study, you must be on your toes. You are on the firing line in the battle for the people's health.

This piece is to be about what you can do to help eliminate the venereal diseases from the ranks of industrial workers. Actually, it will outline a concrete program



Blood tests for all working men and women—including the apparently healthy—are recommended as part of regular placement and periodic physical examinations in industry.

by which you as a nurse in industry can help to organize and stimulate and inspire the workers in your firm to know about their health problems—including VD—and to know what to do about them.

SYPHILIS AND GONORRHEA

To refresh yourself on the facts about the venereal diseases, their nature, spread, prevention and treatment, it might be well if you sent to the American Social Hygiene Association, 1790 Broadway, New York 19, N.Y., for Dr. Max J. Exner's excellent and comprehensive pamphlet, "What You Should Know About Syphilis and Gonorrhea." You might also want the Association's popular booklet, "Questions and Answers about Syphilis and Gonorrhea," which will be a time-saver in answering the many questions which you will be asked as soon as VD is under discussion in your plant. You know the kind of questions some of these will be: Is syphilis inherited? Is a blood test a sure diagnosis? What are the new treatments, the best cures? Can you get syphilis from a cigarette, a drinking cup, a towel, a toilet? Can you get it if you have once been treated? Can you get syphilis and gonorrhea at the same time?

ATTITUDE OF THE OSTRICH

You will be asked these questions or you may run into dead silence. Not only the employees but the personnel director and the head of your firm, all of whom might be quite willing to talk about and do something about tuberculosis, diphtheria, smallpox, infantile paralysis and other serious contagious diseases, may ape the ostrich when it comes to VD. So perhaps your first task will have to be to dispel the miasma of false modesty which even today in 1944 is so greatly responsible for the continued depredations of syphilis the killer and gonorrhea the crippler.

Maybe you can begin by reminding the workers or management or both that they don't let false modesty interfere with the care and servicing of the plant machinery. You might want to point out that outmoded equipment is not kept in use because it was considered tops during the reign of Queen Victoria. While we no longer go in for witch burning, with

respect to facing the facts about VD we are often as narrowminded and prejudiced as some of our inhibited New England ancestors. By yielding to the policy of hush-hush we condemn many victims of syphilis and gonorrhea and their innocent families to needless disease, misery and untimely death.

NOT ACQUIRED FROM TOILET SEATS

Having convinced your people that the syphilis and gonorrhea germs are no respecters of silence, but continue infecting men and women and causing more misery and death than diphtheria, smallpox and infantile paralysis combined, you must be prepared to dispel the false ideas, some mentioned above, on how venereal diseases are spread. The imagined danger of becoming infected with syphilis or gonorrhea by ordinary industrial processes has worried many workers. If they believe that fellow employees have one of these diseases, they may be especially anxious. The truth is that practically no such danger exists.

Dr. Walter Clarke, executive director of the American Social Hygiene Association, has stated that in a large experience he has never seen a person who, in his opinion, had been infected with syphilis or gonorrhea by contact with soiled tools, machines, toilet seats, wash basins, towels, cups, glasses, knives, forks, or spoons, let alone cigarettes. He has further stated that he knows of no well authenticated case so acquired, in the experience of other physicians.

It may be very useful to have these all too prevalent misconceptions about toilet seats, washrooms, and other objects exposed by unimpeachable medical authority. In many plants misinformed employees and employers have made use of such myths to discriminate against groups or individuals. Should such a situation arise in your firm you can be objective and scientific in making it clear that the medical facts about the spread of VD are true for everyone, male or female, white or colored, old or young, rich or poor.

Venereal infections do not spread through inanimate objects because the spirochete, cause of syphilis, is a very delicate germ. It cannot live if exposed to light, heat, cold (except under special laboratory conditions), drying, nor in the presence of soap and water, or any disinfectant. The gonococcus, cause of gonorrhea, is also a delicate germ, easily killed by heat, light, cold, drying, soap and water, and any disinfectant. Dead germs do not cause diseases.

As you know most cases of syphilis are acquired by sexual contacts, a few by kissing. Babies are often infected before birth if their mothers have syphilis but do not receive treatment during pregnancy.

Practically all cases of gonorrhea are acquired by sexual contact. An infant's eyes may become infected at birth while passing through the birth canal of a woman having gonorrhea. Little girls are sometimes infected by close contact with infectious adults with whom the little girls sleep or are in intimate contact in some other way.

WHAT ABOUT PROSTITUTION

To attempt to control the venereal diseases without taking into account the principal source of infection would be like trying to eliminate typhoid while ignoring a polluted water supply. In bringing the facts about the venereal diseases to men and women in industry you will have to work out with them some pretty clear attitudes on the question of prostitution. Many men, and women also for that matter, rarely know just where they stand on this social problem. All too often they approach it with the same evasion and prejudice which blind them to the other aspects of the venereal disease question, rather than with an objective appraisal of the facts.

The facts are indisputable. Prostitution and promiscuous sex relations with pick-ups and "free girls" are the principal sources of venereal disease infection. Studies show that nearly all prostitutes sooner or later become infected with syphilis or gonorrhea—or both. These simple statements, authenticated and proven beyond question, really should be all that need be said on the subject. Do you want to stamp out venereal disease? Then it must be thumbs down on prostitution, free girls, pick-ups and any other such form of promiscuous sexual behavior.

NO "SAFE" PROSTITUTES

Unfortunately, this iron-clad reasoning does not strike home to some of our citizens in high and low places. When cornered with the logical conclusion that the scourge of venereal disease cannot be wiped out unless the source of infection is suppressed, the uninformed advance the argument that prostitutes who are given periodic medical inspections are "safe." There are no "safe" prostitutes. Even if they are inspected by doctors daily, between examinations prostitutes could make numerous contacts with infected persons and infect many others. The American Medical Association has officially stated that "Medical inspection of prostitutes is untrustworthy, inefficient, gives a false sense of security and fails to prevent the spread of infection."

Loose thinking on prostitution is a distinct service to the commercial vice racketeers and the dishonest politicians who share the spoils; investigation has determined that the unfortunate prostitute herself gets only about 20 percent of the take. The commercialized prostitution racket virtually enslaves young women and robs them of the chance to work on socially useful jobs. Furthermore, the free girls of today are the potential prostitutes of tomorrow—unless something is done about this problem.

These pathetic youngsters, the free girls, are now responsible for more than 80 percent of the VD infections among our armed forces. Just as we take our stand and say, "We are against prostitution, not the prostitute," so we must not condemn the delinquent girl but join all community forces in intelligent, sympathetic and constructive thought and action against conditions which let her be what she is.

Although these girls remain a major problem, commercialized prostitution is pretty much under control right now in the United States. Under the patriotic necessity of protecting our armed forces, nearly all "districts" have been closed up, with a consequent lowering of the VD rate in these areas. Led by federal, state, and municipal law enforcement agencies, the American Social Hygiene Association, the Army, and Navy, and backed up by enlightened public opinion, 662 cities of the country during the past year have been able to close their red light districts.

The big question mark remains: Will these wartime gains extend into the postwar period? Underworld elements hope that "when the war's over the signal will be given, and the red lights will go on again." Every individual and every group will have to be on guard to see that this doesn't happen. That's why it's up to you as a nurse in industry to use your leadership in mobilizing management and employees to take their place alongside the other champions of good health, good morals and good government and say: "I'm utterly opposed to tolerating prostitution. Medical certification is the bunk. I refuse to contribute to the prostitution racket."

POSSUM-PLAYING SPIROCHETES

Perhaps you are wondering when I am going to get down to the concrete plan, mentioned at the beginning of this article, for organizing a program of education and action on venereal disease—and other health subjects—in your firm. I'm coming to this program, but first it seemed

in order to present some important background material which is likely to be neglected. That's why I went into so much detail on this matter of prostitution and on the false ideas of how VD is spread in industry. Another point that must be constantly brought to the fore is the deceptive character of syphilis. People must be told that they can have it without knowing it; that the hard sores of the first stage and the rash of the second stage disappear even without treatment but the syphilis germs are still present doing their deadly work.

MASS BLOOD TESTS

As a worker in the public health field you are aware of the important place that education holds in preventive medicine. This is particularly true of the venereal diseases. More than with most other ailments, knowledge of the facts about VD is a major part in the battle to eradicate them. But you also know that all the education in the world won't cure a man or woman infected with syphilis or gonorrhea nor will it find the undiscovered cases among your employees. A clean bill of health for an industrial group cannot be attained unless those who are diseased are found and treated.

The blood test is a practical means of finding cases of syphilis. The same applies for chest X-rays to diagnose tuberculosis. Ideally a blood test should be included in all placement examinations and in periodic examinations of those already employed. Where regular general examinations are not undertaken, special mass blood testing campaigns are still advisable.

Before mass blood testing can be introduced in your firm, it is hardly necessary for me to tell you that a difficult selling job will probably be necessary with both management and employees. In both cases such opposition is understandable and can be overcome only by skillful education. Management will have to be shown that a campaign against VD, including blood tests, will pay in dollars and cents, will reduce absenteeism and will create no bad relations with employees. Employees must be convinced that such a program casts no stigma upon anyone of them individually but rather will protect them and their families and will result in no employment discrimination against those found to be infected.

HIDDEN COSTS

In presenting your argument to management it might be well to begin by pointing out that according to U. S. Public Health Service figures, illness is responsible each year for an average of 8 to 9 days of absenteeism per male industrial worker; 12 to 14 days per woman. There are very wide variations in the rates from plant to plant, and from industry to industry, and this applies to the VD rates as well.

By and large, the cost to industry represented by syphilis and gonorrhea remains an unknown quantity. Many disabilities, illnesses and accidents on the industrial cost sheet appear under different titles, whereas, if the facts were known, they would come under the heading of VD. Judging by the records of the Army and Navy, if industry would learn the facts about its VD problem, these diseases would be found to be a serious cause of lost manpower, of increased compensation costs, of higher taxes, and of labor turnover. The hidden costs of syphilis and gonorrhea in industry undoubtedly amount to tens of millions of dollars each year.

Management should know that the medical profession has up to the minute methods of diagnosis and treatment for the venereal diseases which guarantee great results, especially in early cases. Furthermore, most people under treatment are able to remain at work without endangering themselves, their fellow employees, or the machines they operate. Finally,

and perhaps most important, when people know the facts about VD, they know how to avoid exposure to infection.

In view of all this it should be possible to convince most employers that it is to the advantage of themselves, their businesses, and their employees to face the VD problem in their firms, find out its extent—and do something about it. Enlightened management is increasingly concerning itself with tuberculosis and other health problems and hazards; it must be realistic and do likewise about VD.

Part II of "The Nurse in Industry Organizes Against VD" by Percy Shostac will appear in the next issue.

HEALTH EDUCATION IN SECONDARY SCHOOLS

THE JOINT COMMITTEE on Health Problems in Education of the National Education Association and the American Medical Association met in Chicago March 8 and 9, 1944. The following resolution drawn up for submission to the two organizations represented in the committee is of interest to physicians, nurses and educators.

WHEREAS, health education is an effective method for improving the health of students and for influencing their attitudes toward community health, and

WHEREAS, the Office of Education, with the assistance of representatives from the U.S. Public Health Service, the Children's Bureau, representatives of the armed forces and others, has prepared a suggested program of health education, entitled "Physical Fitness through Health Education," and

WHEREAS, the Office of Education with the assistance of a special committee composed of individuals associated with medicine, education and public health has issued a report on "The Preparation of Teachers for the Program of Physical Fitness through Health Education"; and

WHEREAS, the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association is vitally interested in all efforts to improve the health of the nation through health education efforts; therefore be it

RESOLVED, that the Joint Committee on Health Problems in Education of the National Education Association and American Medical Association endorse the recommendation of the Office of Education that schools throughout the country provide, in collaboration with suitable medical and health authorities, programs of health education for all secondary school students, adapting the suggestions contained in "Physical Fitness through Health Education" to the particular needs and problems of their students and community; and be it further

RESOLVED, that the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association urges that school administrators provide sufficient allotments of time to permit an integrated health education program that includes such topics as accident prevention, nutrition, disease prevention, first aid, functioning of the human body, community hygiene, correction of remediable defects, the dangers of self-medication and of fads and quacks, home care of the sick, mental hygiene and the use of professional health services; and be it further

RESOLVED, that the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association, urges that teachers of health education be adequately prepared in health education and that state departments of education prepare specific requirements for those who are and those who will be responsible for secondary school health education.

This resolution was adopted by the House of Delegates of the American Medical Association at its June meeting.

Arctic Nurses

By REV. PAUL C. O'CONNOR, S.J.

I BELIEVE THAT there are few people in Northern Alaska who really get around their respective districts like a Jesuit missionary. Traders take an occasional jaunt to visit their branch stores to pick up fur. Deputy marshals go out to corral a disorderly native. Game and fish commissioners hike here and there to watch their preserves. But a missionary is on the loose. He goes and comes when he wishes; stops at native cabins, eats native food (when hungry!); even hunts and fishes with the Eskimo, picnics with them and listens to their comments on life and people. What's more, he generally stays in the country long enough to understand the Eskimo. This is a kind of boastful preamble, but what I am getting at is that when we speak a word or two in praise of government nurses, we know what we are talking about.

Government nurses working in behalf of the Eskimo are generally taken pretty much for granted. They have always been around and for that simple reason, at first sight, they seem not to be appreciated. They are something like a mother in a home. The children accept her without question, throw a lot of work her way. She does it as a matter of course and little expressive thanks is offered. Things go on like this for years with the same unresponsive attitude on the children's part. Much is given by the one, little returned, at least apparently, by the other. Yet underneath there is deep affection and it only manifests itself at the loss of the mother. Like the air we breathe or the sun that shines, her value is never really properly estimated, until it is withdrawn.

I can well imagine that a government nurse must think that her life is very prosaic. She does her job, a job requiring sometimes a lot of downright drudgery and self-effacement. Sometimes she is rewarded with a smile, more often, just taken, as I said before, as a matter of course. As so often happens the well-doer does not see the complete picture. It is the one on the outside looking in that may perhaps get a better perspective. I know for one that I have heard much praise showered on nurses that has never reached their ears. I have been able to see the reaction of the patient when he has returned home and has time for reflection on the kind treatment received.

Permit me to quote one example which I could easily multiply by ten. An old Eskimo woman had been taken to our local hospital. She was a very sick woman. I myself did not think she had a chance. There was no doctor around, but by careful and kind treatment the patient was sent home well. Some weeks later I casually dropped in on this Eskimo. One thing led to another, but in the course of the conversation these words came out, "Father, I never knew how good those nurses were. They treated me like a white woman." The way and manner of these simple words manifested deep and heartfelt gratitude. Another old man told me, "I am not worth the care they give me."

I perhaps have more leisure to think than the nurses who are on the jump from morning till night. I have often thought that during these days of material progress so many fine brains and beautiful personalities are engulfed in mechanical work.

This kind of labor may be good, but it is not the best. The close contact with people as people, and the solicitous servicing of their ills is the job that has the lasting effect on humanity. In very truth the nurses have chosen the better part.

Nor is their ministry confined solely to the hospital. I have met nurses traveling under conditions that require pioneer hardihood. They really take it on the chin. It may be in sub-zero weather crossing the tundra by dog-team, on a rough sea in a smelly Eskimo skin-boat, in a rickety plane crossing snow-capped mountain ranges, but no matter what hardship—they do it and give the appearance of liking it.

I remember a year or so ago, I was mushing in early spring. It would be impossible to describe adequately the trip. I will sum it all up in three words—rain, slush, and overflow! I staggered along this forbidding Arctic coast soaked to the skin, hungry, tired, grouchy, and miserable. I almost pitied myself! I got in to Kotzebue at 7 p.m. Hours later Mrs. Clara Gaddie, our traveling nurse, came over the same trail. When I met her the next day, she dismissed the whole episode with a smile. I was almost ready to crown myself a hero—until I met her!

Some days when the north winds are howling down through the Noatak Mountains and life is particularly drab with me, I wander up to the hospital for a mental pick-up. The wards will be filled to the brim with Eskimos with hideous skin diseases, running sores, and what-not. Amid this rather unpleasant setting I meet Miss Hartmann and Miss Harris trim and fresh looking as newly plucked flowers. The fact that a doctor is not within 500 miles does not get them down. They know their job and do it. Incidentally, the bland faces of the Eskimos may not show much appreciation, but their hearts do, and I know it. Kind and sympathetic treatment cannot help but register.

On the Trail

To a Home Visit

In Eskimo Garb

Reasonable Treatment of Acute Poliomyelitis

By JESSIE WRIGHT, M.D.

SO MUCH HAS been said and written in the past few years about the treatment of infantile paralysis that the physician directing care of such patients as well as the nurses and physiotherapists carrying out the treatment would like a basic, common sense foundation of acceptable procedures upon which variations to meet the needs of each individual case can be made. To become lost in a labyrinth of details regarding one method of applying physiotherapy such as by use of packs is to lose perspective in regard to the disease as a whole.

When the patient with acute poliomyelitis is admitted to the hospital, after a careful diagnostic study and assurance of mental and physical rest, the first consideration is for nourishing fluids, taken frequently in small amounts. If the patient is too ill to take fruit juices, vegetable juices, or clear broth, intravenous nourishment should be given in the sequence mentioned later in the discussion of bulbar palsy. Hypertonic fluids are preferred to water or ice chips since the nourishing fluids help to limit or decrease effusion and edema in the affected areas of the cord and in surrounding structures. Liquids that become thick or stringy after ingestion should be avoided, especially in convalescent patients after embarrassment of breathing and swallowing. Moistening the lips with equal parts of lemon and glycerine adds to the comfort during early days of acute illness. Although occasionally diarrhea is an early symptom more often constipation is present and hard to combat. Recent studies show that the virus is present in the stool in variable amounts in victims of the disease and others. Few patients can expel enemas even after saline catharsis. We have found most useful the same approach to this problem as used after certain trauma or operations—prostigmin, plus atropine if the patient is over six years, dosage according to age and size, followed in 10 minutes by an enema. Older patients have remarked that if the enema is delayed after the increased peristalsis, the bowel contents cannot be expelled. By keeping the hand on the abdomen and having all equipment ready, the nurse can feel and sometimes hear the beginning of increased bowel activity and can give the enema at an optimum time. Proper nourishment and elimination of body wastes may decrease fever and add greatly to the feeling of well-being. Often elevation of temperature is not due entirely to disease processes but partly to disregard of the above basic needs.

Prevention of prolonged back lying adds to comfort and limits stasis of circulation in the back muscles and the posterior part of the trunk. Prone lying facilitates drainage of lymph and venous blood from the region of the cord and makes way for fresh arterial flow. The average patient with acute poliomyelitis may be turned as a whole every two hours, avoiding segmental movement of one vertebra on another for fear of aggravating the inflammation in the cord.

Most patients with trunk or extremity involvement need relief from pain, tenderness, and muscle tension. Drugs are not

effective in relieving this type of pain. Opiates and many sedatives are dangerous in case of involvement of the medulla oblongata, further distress in swallowing and breathing resulting. Besides relief of pain, the objects of any physical treatment must be to improve circulation through the skin, subcutaneous tissue, and muscles, thus mobilizing products of metabolism which have been locked in tense muscles and facilitating replacement by fresh arterial blood bringing nourishment and oxygen to aid restoration of metabolic balance.

MOIST HEAT

Moist heat when used for sedation and decongestion is applied at its hottest degree and gradually loses heat so that when a fomentation is removed it is cool, giving a mild contrast of temperature for vasomotor tonic effect. The expression "continuous hot packs" should be avoided since if taken literally and so applied would result in failure of vasomotor response with more congestion and stasis in the neuromuscular system, and in all body parts. According to Hilton's law, the trunk of a nerve, sending branches to a given muscle, supplies branches to the joint moved by the muscle and to the area of skin over the muscle. In a peripheral nerve trunk we have the axon cylinders of lower motor neurons whose cell bodies are located in the anterior column or horn of gray matter of the spinal cord, the same anterior horn cells which show the chief residual damage after an attack of infantile paralysis. In the acute illness a general insult is evident affecting many parts of the nervous system and other systems of the body. Carey and others have shown experimentally that when the anterior horn cell of the lower motor neuron receives inflammatory insult, its axon and neuromuscular junction undergo inflammatory reactions. These reactions may irritate fibers of sensory neurons traveling in the same nerve trunk sheath but not primarily involved in the disease. The sensory fibers which pass through a muscle and are distributed to the skin may be irritated by inflammation in the nerve sheath and by pressure of the tense muscle through which the nerve travels. Tenderness and parasthesia in the skin are relieved by moist heat more than by dry heat. Moist heat decreases the intensity of sensory afferent impulses reaching the central nervous system and tends to make both the muscle and the patient relax, thus giving more freedom of channels for circulatory interchange, relieving ischaemia which is one cause of muscle spasm or cramp. This results in improvement of general circulation with relief of stasis in all body parts including the cord, nerves, and muscles.

In our experience dry heat is not so effective in accomplishing the above changes. Dry heat builds up intensity the longer it is applied and is usually greatest at the end of the period of application or radiation, having just the opposite effect from the fomentations previously described. Dry heat or continuous moist heat used over a great part of each day leads to vasomotor failure with passive congestion and stagnation of circulation resulting in aggravation of inflammatory processes.

METHODS OF APPLICATION

Moist heat to be effective does not need to be applied only in one way covering each affected part, with joints free. This method advocated by the Minneapolis group is satisfactory in some patients. Others are more comfortable if not hemmed in by snugly wrapped packs; in such cases or in patients too ill to tolerate even careful handling of affected parts, a fomentation may be applied to the free surface of the body and tucked around affected parts, then covered by waterproof material and an outside layer. No matter what the technique of application of fomentations, certain cautions must be observed. The woolen material must be wrung dry enough to eliminate free mois-

ture which might cause a hot water burn. After the fomentation is ready for application, it should be momentarily held out flat so that no pockets of steam remain. Quick application is desirable; but initial fomentations should not be at full heat since sudden application of intense heat to a sensitive part of an apprehensive, acutely ill patient may result in rigid, protective tension of muscles and fear of future packs. It is not an uncommon experience to observe someone so carried away by a dogmatic statement that "packs must be hot to be effective" that no concern is shown about a cry of terror from the newly affected patient or by increase of muscle spasm resulting from defense reaction. There should be psychologic preparation of the patient for any nursing or physiotherapy procedures, including applications of fomentations. After a few applications of moist heat at 105°, 110°, and 115° F., a fomentation tested by thermometer just before application and found to be about 120° may be tolerated. Some patients become prostrated after moist or dry heat, due to poor vasomotor tone, severe toxemia, or humid room air. The pulse and temperature must be watched carefully and fomentations reduced in number or time of application if profuse sweating and rapid, thready pulse occur. Sometimes all packs must be stopped and tepid or cold sponging used to restore vasomotor tone. If sudamina occurs in hot weather, the skin must be kept dry. In humid weather, circulation of air, avoiding a direct current on the patient, but encouraging evaporation of excessive air moisture, should be assured. Since fomentations are used for the purpose of relieving pain and muscular spasm or tension, as soon as this objective has been reached the moist heat should be stopped or one observes an opposite effect of dulled skin perception and of hypotonia. Transition should be made then to tonic applications such as the contrast of alternate hot and cold water, or protected movement in a therapeutic pool.

PHYSIOLOGIC MOVEMENTS

Physiologic movements used as early as possible give one of the greatest aids to circulation and encourage restoration of muscle and joint function. Passive motion is tried first as soon as a painless arc is present. The affected part should be lifted carefully and moved gently, stopping as soon as one feels the slight resistance to movement which occurs before the patient experiences pain and before the muscle offers reflex resistance or spasm. When a complete arc of passive motion is attained, proprioceptive stimulation may be brought into play. Stimulation of nerve endings in the tendon sheaths, intermuscular septa, joint linings, and periosteum, by passive tension on a muscle and its attachments, increases the patient's kinesthetic or muscle sense. Such proprioceptive impulses travel along sensory afferent pathways which are not involved primarily in poliomyelitis. Therefore we take advantage of them in passive movements to make the patient sense the location of the muscle for anticipated active effort.

MUSCLE REEDUCATION

When trial of voluntary use of a recovering muscle no longer causes quivering of muscle fibers (seen in small groups of fibers as fibrillation, or in a whole, gross muscle as spasm), then reeducation is in order. The course of the muscle to be used is pointed out from insertion to origin, or in small children, the skin over the muscle may be stroked. The instructor should be alone with patient and the full attention of the patient should be commanded. After indicating the course of the muscle, the instructor carries out the appropriate movement gently and rhythmically while the patient concentrates on the movement. After these preliminary maneuvers, the patient contracts the muscle while the movement is guided and assisted by the instructor. Initial effort is usually one active movement carried out several times a day according to the age and tolerance of the patient. Accuracy of

effort and avoidance of substitution are important. Obviously the number of active movements and frequency of exercise periods will vary according to the individual needs. An experienced physiotherapist will combine reciprocal action (using agonist and antagonist) with individual muscle training when indicated. Often such muscles as the gluteus medius need individual muscle training against gravity after initial reciprocal action if sufficient strength is to be obtained to walk without a medius limp.

Frequent alignment of affected parts, every two hours or more often, is in effect splinting. Feet and knees should be protected appropriately, when back or prone lying, to prevent distortion. Children under six, who do not appreciate the importance of positions of physiologic advantage, should have light removable casts or similar support during the night and sometimes part of the day to offset tendency to deformity.

In the recent seasonal outbreak of poliomyelitis in Pittsburgh, abortive and nonparalytic patients with suggestive spinal fluid findings have been treated by high vitamin diet, attention to daily elimination of body wastes, then, as soon as the temperature became normal, passive and active exercise to restore normal body mechanics and muscle pliability. No thermotherapy or hydrotherapy has been needed. Care must be used in restoring normal flexibility to the facet joints of the spine and to relieving hamstring shortening. Elaborate treatment of such patients is unnecessary.

BULBAR INVOLVEMENT

The patients with bulbar involvement, shown clinically by nasal voice, limited movement of the soft palate and pharynx plus shallow, irregular breathing were helped most by hypertonic intravenous solution of quality and quantity according to age and size of the patient and the degree and length of time of involvement. A slow, continuous drip of 10 percent dextrose followed by plasma, then 5 percent dextrose in saline was given during 12 daytime hours. An ice cap at the top of the head or iced compresses to the forehead added to comfort. Fomentations on the neck and any other affected part were not well tolerated by most bulbar or bulbospinal cases. Such patients admitted before severe embarrassment of swallowing and breathing, recovered best by use of the above parenteral nourishment, due attention being given to favorable position for drainage of mucus and continuous or intermittent aspiration as needed. Deaths occurred in patients admitted in a moribund state and in several teen age boys who had been exhausted from overexertion previous to onset of bulbar symptoms before admission to the hospital. Patients with bulbar involvement who had taken large quantities of water or ice chips at home while still able to swallow took longest for recovery of ability to swallow and to speak without the nasal voice characteristic of soft palate involvement. This observation suggests that hypotonic solutions may increase edema and inflammatory stasis in the medulla oblongata while hypertonic solutions decrease the swelling and congestion in and around the affected nerve cells drawing fluid into vessels and giving quicker return of function. Physiotherapy in the form of fomentations was of minor importance in this group of acute cases.

Fomentations were helpful to one boy of 12 who was admitted with rigid neck, jaws, abdominal wall, and fully expanded chest. When he attempted to talk it was obvious that he was holding his breath. He could not exhale due to spasm of the intercostals and diaphragm. His color was good—not cyanotic. History and spinal fluid findings as well as anterior neck and quadriceps weakness plus hamstring spasm without sensory involvement had made the diagnosis clear. Fomentations applied to the neck, back, chest, and abdomen relaxed the tension and in one hour the chest was moving freely. He was instructed in ex-

haling and inhaling rhythmically. Recovery was rapid and uneventful. Fomentations were of striking benefit in this case.

CORD INVOLVEMENT

Most of the patients with involvement of the cervical and thoracic cord, including anterior horn cells related to muscles of respiration, responded well to the routine already outlined. In these patients who could not inhale freely fomentations were very helpful and may have been instrumental in relieving the strain of breathing which caused use of accessory muscles of respiration and resulted in cyanosis. Three patients with primary respiratory muscle involvement were admitted in a state of exhaustion after being ill at home. They all showed straining with accessory muscles of respiration and also cyanosis. Their condition was so critical that no time was available for general supportive treatment previously mentioned which in similar cases has made use of the respirator unnecessary. They were placed in respirators at once as a life saving measure. The first man admitted had impairment of leg muscles also. He was 27 years of age and has cooperated well. After two months he is able to be out of the respirator one hour three times a day, at which times his arms and legs are moved through a bigger arc than when he is in the respirator. The second of the three admitted was a 15-year-old boy with additional involvement of arms and legs. After six weeks he is able to be out of the respirator forty minutes three times daily. The third patient, a married woman, was moribund when admitted, with involvement of neck, trunk, arms, and legs. She started being out of the respirator one minute at a time as did the others, and after a month is able to be out eight minutes three times daily. None of these patients responded to even partial packs. They became exhausted and weaker. But they tolerated movement of affected extremities every two hours, and side lying propped by pillows. Many interesting variations have been introduced in the treatment of these three patients to avoid stiffness and assure mobility and improved excursion of the chest. Enough description of reactions has been given to indicate that *treatment cannot be by one method only but must meet the needs of each case.* These patients did not tolerate moist heat but benefited by kinesitherapy.

In the average case of poliomyelitis with some trunk and extremity involvement, after the initial care outlined in the first paragraphs of this paper, fomentations used according to the needs of each patient form one of the best aids in relieving pain, preserving or restoring good tissue tone, making muscles more pliable, and permitting freer range of joint motion so that physiologic movements may be started early.

In view of the argument advanced that spasm of one muscle "alienates" its antagonist, we have been interested in watching the effect on the antagonist after moist heat has relaxed the muscle in spasm so that a complete arc of painless passive motion is possible. When this has occurred, one would expect the inhibited muscle to respond to active muscle re-education after a short time. We noticed that some inhibited muscles had rapid return of function after relaxation of an opponent in spasm; others made a partial recovery; while still others continued to give no response and were finally characterized by typical flaccid paralysis, suggesting permanent damage to anterior horn cells of lower motor neurons. In the last type, even if tone of skin and subcutaneous tissues was good after initial intensive treatment, and spasm of the opponent was relaxed, resumption of even a restricted daily program at school or work resulted in tendency for the muscle that had been in spasm to have adaptive tissue shortening with hypertrophy and fibrosis, and for the muscle that had been inhibited to atrophy. This sequence was followed by the usual tendencies to physical deformity

requiring adequate bracing or operation.

SUMMARY

An attempt has been made to suggest how the best procedures from all methods of treatment may be used when indicated if one understands what is to be accomplished. A reasonable outline of essentials in modern consideration of infantile paralysis may be as follows:

1. Careful diagnostic study.
2. Mental and physical rest, with constructive psychotherapy.
3. Adequate liquid nourishment.
4. Elimination of body wastes.
5. Bed positions to favor circulation in the back and the region of the spinal cord, plus change of position to prevent passive congestion in dependent body parts.
6. Sedative physiotherapy.
7. Physiologic movement of affected parts as soon as body temperature is normal and a painless arc of motion is present.
8. Accurate, localized muscle reeducation as soon as active motion is possible without pain or muscle irritation.
9. Frequent alignment of affected parts to limit tendencies to deformity.
10. Removable light casts or splints especially for night use in small children who cannot hold prescribed positions.

The public and relatives of patients should be educated to know that the possibility of recovery or eventual paralysis is determined largely at the onset of the disease. If anterior horn cells of lower motor neurons are destroyed during the acute phase of the disease, no treatment will restore power to related muscle fibers. On the other hand, by early, judicious care, surrounding nerve cells may be saved from permanent damage due to congestion and circulatory stasis, and muscles in affected parts may be saved from unnecessary atrophy or fibrosis. The only way that paralysis may be prevented is by controlling the disease at its source which is at present unknown.

In late convalescent and chronic cases we continue to have the same problems which have arisen through the years for improvement of function or correction of deformity and which must be met by appropriate braces or operations. Even patients who have achieved a good recovery of muscles and restoration of normal body mechanics must maintain a protective balance between rest and activity through life if regression is to be avoided. While we greet new ideas with enthusiasm, we must keep our feet on the ground.

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Auxiliary Workers

By ELISABETH C. PHILLIPS, R.N.

AUXILIARY workers fall into two categories, unpaid and paid.

VOLUNTEER WORKERS

The use of volunteers in public health organizations is not, of course, a purely wartime measure. However, many agencies have discovered new ways to utilize help from volunteers, and most of them have been able, through a variety of methods, to secure such workers. Until recently probably few agencies have kept accurate records regarding the amount of volunteer services which they have had. Even now, it is not easy to secure definite reports. I have just recently been in conversation with representatives of the New York City Department of Health and the Brooklyn Visiting Nurse Association regarding their volunteer time and their comments are included with mine from the Visiting Nurse Service of New York. Each agency would like it to be emphasized that in addition to the recorded amounts of time they are sure that there have been innumerable hours given in addition. For instance, only time is included here which saves the nurses time—this eliminates all fund raising and allied activities. The Brooklyn VNA reports that in 1943 it was the recipients of 1,677 volunteer hours. The New York City Department of Health was given 40,024 hours, and the VNS of New York, 12,129 hours, a reduction of 3,282 from 1942. The last two agencies have attempted to translate this time into cash values. The Department of Health feels that its volunteer time has been the equivalent of $23,414, or about 58 cents per hour, while the Visiting Nurse Service of New York has computed it to be $5,662, approximately 46½ cents per hour. The last organization has broken this figure down as to the type of service donated: clerical service $3,952, nursing service $1,210, and supply room work $500. These cash values were calculated by the VNS of New York as follows:

1. For clerical services the number of hours times the minimum clerical hourly salary. This minimum salary was used because it was recognized that a full-time clerk would probably accomplish more than a variety of volunteers working an equivalent number of hours, although some volunteers become so proficient that they accomplish far more than the new, untrained clerk with far less direction from the supervisor.

2. For nursing service the number of hours given were multiplied by the average salary cost per visit by a professional nurse.

3. Supply room work was estimated upon the actual difference in price between cotton rolled by hand and aprons made by volunteers and the same articles purchased in a ready-to-use form.

In the Department of Health, on the other hand, all volunteer services were given to relieve nurses and therefore the total time was computed upon the average hourly salary of the nurses. This accounts for its being higher than in the VNS.

Last year the insurance companies accepted the principle of charging the value of volunteer services to the cost per visit of the Henry Street VNS. This raised

the cost per visit approximately one cent for 1942. This is also true for 1943.

We believe that it is important to take this final step of translating hours into cash values, lest we make a serious mistake at the time that we make the budget and not include this considerable amount either on the credit or the debit side. How would this expense be met if it was suddenly withdrawn? How will it be met after the present emergency when, perhaps, there will be fewer volunteers?

If the volunteer program is to be successful there seem to be a number of "musts" which must be satisfied:

1. There must be an organized administrative set-up which will be responsible for recruiting volunteers and possibly for some of their basic instruction. Much of this responsibility can doubtless be taken by carefully selected volunteers themselves who are familiar with both the program of the organization and the duties expected of the volunteers. While much of the introduction of the volunteer to her job can be done locally, still there must be someone to whom the volunteers are responsible for work and time reports.

2. There must be a definite job analysis so that specific offers can be made to the volunteers.

3. But probably the most important factor of all is a realization of her worth by the volunteer herself and by the nurses whose time she is there to save. More and more agencies are finding now that a symbol which indicates that the volunteer has made a real contribution is invaluable in the stimulation and satisfaction it brings. A minimum of hours service over a designated period must be set before the award can be given. The VNS of New York gives a pin after 150 hours service while the New York City Department of Health has set a requirement of 500 hours for its award and adds a special ribbon for 1,000 hours.

There is one word of warning which I would like to give to agencies which are contemplating using young people as volunteers. Until recently we, like many other organizations, have been in the habit of getting some help from teen age girls and boys. This spring, however, we have decided to discontinue this practice unless the child has working papers, or the work is designated as a group project under a recognized leader as might be the case with a scout troop. The reason for this decision is that there have been in the New York City area several successful prosecutions of social agencies despite the fact that the parents of the children have given their written consent for work with the agency at specified periods. I would strongly advise anyone to investigate this situation in her own state if she is now using such help or is so contemplating.

PAID WORKERS

Clerical. I believe we are all agreed that many duties of the public health nurse are clerical. Long before the war attempts were made to relieve her in this respect. We agreed that clerical time was cheaper than nursing time. This is still true although the salaries for this type of worker have risen considerably. In 1940 the Henry Street VNS, as the result of careful study, planned to revise the budget so that more clerical assistance would be available to make nurses freer for other services to patients. An experiment was outlined in one of the centers whereby three clerks would be put in a center and the assistant supervisor moved away. However, these plans were never put into effect. In the fall of 1941 and again in 1942 it was decided to employ more clerks. But today we have no increase in the clerical staff. Indeed, good clerks are about as hard to come by as good nurses, and the turnover is just as great! I hope that in the postwar plans we remember to make provision for removing from the nurse all purely clerical duties.

Maids. At the VNS of New York we now employ many more maids on a part-time basis than we did formerly. While I have no specific figures to present, I'm

sure you will agree that a maid who cleans a nurse's bag at an hourly wage of 50 or 60 cents is saving us both money and nursing time.

Practical Nurses. In a study of 584 agencies made by NOPHN in 1942, only 16, or 3 percent, reported that they employed practical nurses. I hope that figure is larger today.

The VNS of New York, formerly the Henry Street VNS, believes that by employing practical nurses the organization can more adequately meet the needs and contribute to the total health services of the community. By relieving the professional nurses of care that can be equally well given by practical nurses each public health nurse is enabled to extend her public health activities over a much wider area. The first practical nurse was employed with this agency in November 1942. Throughout 1943 we averaged 11½ practical nurses on the staff and for the past six months we have had 18. In all, we have employed 25 practical nurses from 5 schools of practical nursing. The average age of these practical nurses is 39 years, while that of our full-time public health nurses is about 33. They have been assigned successfully to 15 of our 16 district centers.

During 1943 our practical nurses made 16,263 visits or 3½ percent of the total visits made by this organization. They averaged 1,378 visits per nurse, while the public health nurse averaged 2,037. There are two major reasons for the practical nurses' not making so many visits as the public health nurses: (1)Their travel time per visit averages 16.1 minutes, while that of the public health nurse is only 8 minutes. This is because there is a careful selection of their cases based upon need alone and the patients may live anywhere within the large district. (2) The length of visits made by practical nurses averaged 44.1 minutes, while those of the public health nurses were 28.4. This is because they are deliberately given patients who require lengthy bedside care.

The use of practical nurses results in no saving of dollars to the organization. The salary cost per visit averages for the practical nurse about 93 cents while for the public health nurse it is 94 cents. This salary cost per visit is of course high because the practical nurse does not make as many visits per year and her salary is not far below that of the average public health nurse.

The practical nurse assists the public health nurse in the care of patients but is never totally responsible for the complete care of any patient. The patients whom the practical nurse visits alone are usually those with long-time or minor illness, who *at the time of the visit* require no teaching and whose needs at this point can be met satisfactorily by the practical nurse. The practical nurse's duties are limited to those activities which she has learned in her basic preparation and such procedures as the public health nurse would normally teach a responsible member of the family—always remembering that when a patient or member of the family is taught to give care it is they who assume the responsibility, while if the professional nurse teaches the practical nurse in our employ to give care or treatment, the responsibility must be assumed by the agency. As a rule the practical nurse gives general care, applies clean dressings, gives insulin injections, simple douches, enemas, and simple rectal treatments. She is not expected to take care of complicated cases, do sterile surgical dressings, give intramuscular injections, high colonics, colostomy irrigations, catheterizations, or bladder irrigations. Nor does she, in our agency, give care to well babies, since it is our policy to make visits to normal infants only for teaching purposes as part of the family's health supervision. Neither does the practical nurse visit home-delivered postpartal patients since the public health nurse utilizes every teaching opportunity which such visits present.

The practical nurse works closely with the public health nurse and her visits are

interspersed with periodic visits by the public health nurse. The public health nurse remains responsible for the patient and confers with the practical nurse after she has made a visit. In order to facilitate this scheme the practical nurse is asked to write on the usual public health nurse's record a resumé of her visit. This she does in green ink so that it will stand out and be readily seen by the public health nurse and the supervisor. Sometimes the public health nurse and the practical nurse visit together in the home. This practice, however, is not encouraged since it is our general policy to utilize members of the family in helping to give care where two people are needed to do it. The public health nurse is responsible for making the first and last visit to the family and for explaining to the family that a practical nurse will visit periodically. The public health nurse obtains the doctor's orders and asks his approval before the practical nurse visits the patient. All subsequent contacts with the physician are likewise made by the public health nurse. Responsibility for spacing of visits also belongs to the professional nurse and this she does after consultation with the practical nurse regarding the situation. She plans with the practical nurse to meet the needs of the patient and watch his progress. The arrangements for payment for the nurse's visit are made by the public health nurse but the practical nurse collects the fees at the time of her visits. There is no discrimination between the fee paid by the patient for a visit made by the public health nurse and the one made by the practical nurse, since we believe that all care that is needed by the patient at the time of the visit is given by the practical nurse. This principle has also been accepted by insurance companies and all others who purchase service from us on a contract basis.

The practical nurse has a distinctive uniform made by the company which makes the public health nurse's uniform. It is very similar in style but it is gray rather than blue and her aprons have the word "Practical Nurse" written on the bib. Thus she is easily identified as an auxiliary. At the present time she wears a tailored coat and hat. However, we are hoping by fall to have one especially designed for her. She carries a bag similar to that carried by the public health nurse. but equipped only with needed material.

The practical nurse's annual wartime salary scale for a 44-hour week begins at $1,452 per year ($121 per month) and goes to a maximum of $1,742.40 ($145.20 per month).*Recommendations for salary increases are made by the supervisor on the basis of performance at six months, one year and two years. These salaries compare favorably with those of professional nurses for the maximum salary of the practical nurse at the end of two years is exactly the same as the beginning salary of the professional nurse who has had no advanced preparation in public health nursing. So far the turnover of practical nurses has been 33.3 percent. For full-time public health nurses it is 18.4 percent and for substitutes and part-time nurses 65.5 percent. If all the professional workers are averaged together the professional and practical nurse turnover is the same—33 percent.

Although the use of practical nurses on the staff of a public health nursing organization does not create a saving in dollars and cents we are of the firm conviction that, by saving the public health nurse's time and relieving her of many hours of tedious care, their employment is more than justified after the war as well as during the emergency.

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*On July 1, 1944 the salaries of all staff nurses were raised 5 percent.

Presented at NOPHN Committee on Cost Analyses Meeting, Biennial Convention, Buffalo, New York, June 6, 1944. For additional information on the same subject see article on "Practical Nurses" by Miss Phillips in the *American Journal of Nursing* for this month.

Bringing Low-Priced Garments Back on the Market

By CALLA VAN SYCKLE, Ph.D.

ONE OF THE serious buying problems for consumers in the past year has been to find on the market low-priced everyday garments of satisfactory quality, particularly cotton garments. Manufacturers have quite generally found it more profitable to move into higher price-line garments. There have been ceiling price regulations for clothing but, except in the case of rayon stockings, no way for consumers to know the ceiling prices and to check them against selling prices. Because of lack of enough funds, there has been relatively little investigation by the Office of Price Administration officials of retail prices. In addition, there has been a shortage of certain common cotton fabrics of good quality because of military demand and manpower problems of textile mills. The Office of Price Administration has not been able by itself to move into dollars and cents pricing tied to quality standards in this field. Rationing has not been used to control the demand for clothing. All of the disadvantageous factors have added up to serious shortages of low-priced clothing.

A government program especially aimed at bringing back into the market a number of low-priced clothing items is now under way. It is a joint undertaking of the Office of Civilian Requirements (OCR), the War Production Board (WPB), and the Office of Price Administration (OPA), under the direction of the Office of Economic Stabilization (OES).

Briefly, the program includes certification by OCR to the low-priced items for which an added production is necessary; priority assistance making the necessary fabrics available to manufacturers and setting up of garment standards and specifications by WPB; establishment by OPA of ceiling prices at each level of sale for each garment included in the joint program.

The first price schedule in the proposed series became effective July 7. The garments priced are men's shorts, men's dress shirts, women's house dresses and women's and misses' cotton slips—all in the low-price lines. Prices are tied to minimum standards of basic dimensions for each size, to fabric specifications, to minimum standards of construction, and to minimum yardage requirements per dozen garments in each size range. Retail ceiling prices for garments covered by the regulation and meeting the standards and specifications set by WPB are as follows:

Item	Size	Retail price per garment
Men's shorts	28-44	$0.39
Men's dress shirts		
(a) Printed and solid colors	14-17	1.39
(b) White	14-17	1.39
House dresses	12-44	1.49
	46-52	1.69
Women's cotton slips	34-44	.65
	46-52	.75

The following example of standards and specifications for the garments priced is taken from those for house dresses:

1. Fabric—68x64 threads per square inch, 39-inch print cloth. This is a rather coarse material compared to the popular 80x80 print cloth which has "gone to war." Colorfastness to laundering: "good" which means colorfast if laundered carefully in lukewarm water.

2. Minimum basic dimensions in inches for finished dresses (selected sizes):

Size	16	18	42	44
Length	42	42	44	44½
Bust	39	41	47	49
Hip	40½	42½	48½	50½
Sweep	58	60	66	68

3. Seams and stitching: "All structural seams shall be made with a fabric allowance behind the stitch line of not less than ½" before pinking, overlock stitching or other treatment, and shall have not less than 10 stitches per inch. Bottom hems on straight line garments shall be not less than 1" and not less than ¼" on flare or swing styles."

The specifications are ***minimum*** and there are other details that make for good wearing quality. Consumers will do well to examine dresses carefully both inside and outside. Look for trueness of cut, that is, a garment cut so that the lengthwise threads are straight down the middle of the back; look for sturdy buttonholes if buttonholes are used; look for adequate seam allowance in armholes, side seams, and at waistline so that seams will not pull out. Look for the "ease" of cut in armholes, sleeves, back and skirt which will allow for freedom of movement and for some shrinkage. Look at the hem to see that it is turned up accurately and the fullness adjusted evenly so that it will not pull out of shape when washed and ironed. Try the dress on to check on fit and comfort in wearing as well as on becomingness. Notice particularly whether the sleeves are set in properly and whether the armholes are big enough.

Type is specified for all of the garments priced except house dresses. Men's dress shirts are "of the regular soft collar type having a six-button front and one pocket." Men's shorts are of "three button yoke type with tie sides." Slips are either "built up shoulder or bodice" (strap) type.

More construction details are given for shirts than for the other garments. For example: "Side and yoke seams shall be made with not less than 14 stitches per inch. Top stitching in collar shall have not less than 16 stitches per inch. The shirt shall have a full center pleat and shall have linings at the center strip, cuffs, collar and band." Weight of linings is specified and the lining fabric "shall be shrunk to the same extent as the body fabric." "The shirt shall be made with side gussets or other suitable side seam reinforcement."

"Men's dress shirts" is the only one of the items priced having a shrinkage standard. The fabric "shall be shrunk so that residual shrinkage is not more than 2 percent." This means that the shirt will fit after it is washed as it did before.

The garments which are produced under these WPB allocations and specifications must be marked with special tags or stampings upon the individual article. The marking required includes:

(a) The manufacturers' WPB case number.
(b) The OPA dollars and cents ceiling price.
(c) "Second" or "imperfect" if the garment is in one of these classes.

If any part of the required marking has not been done by the manufacturer, it must be supplied by the retailer. The manufacturer must furnish to the retailer upon request the necessary information for correct marking. The marking must be securely attached or stamped on the garment itself where it is clearly visible to retail purchasers.

A second in the series of dollars and cents pricing programs for low priced garments went into effect in August. This adds maternity dresses and slips to the previous list.

Certain of the specifications together with the retail ceiling price of these garments are shown in the table following.

Complete details of the pricing and specifications for the garments listed are to be found in MPR 547, obtainable from any OPA office, and M-328B Schedule A, Supplements I, II, III, IV, and V, obtainable from any WPB office.

The success of these programs will depend to a great extent upon the cooperation of manufacturers and retailers. Con-

sumers should find these garments on the market now or very soon although the number that can be produced from the cotton goods available is considerably less than enough to supply the expected demand. Comments on this program by those who have first-hand experience in buying and using the garments should be sent both to the Consumer Goods Division, Office of Price Administration, F. O. Bldg. No. 1, Washington 25, D.C., and to the Textiles, Clothing and Leather Division, War Production Board, Washington 25, D.C.

SPECIFICATIONS AND RETAIL CEILING PRICES—MATERNITY DRESSES AND SLIPS

Item	Size ranges	Fabric allowed	Seams and stitching	Retail ceiling price: In stores buying direct from manufacturers	Retail ceiling price: In other stores
Cotton maternity dresses. One piece type adjustable at waist line.	12-20	Same as for house dresses	Same as for house dresses	$1.89	$2.00
Cotton maternity slips. Straight line strap type adjustable at waist line.	32-44	Same as for house dresses	Side seams with not less than 12 stitches per inch. If not bound, seams to have not less than ½ inch fabric behind the stitch line before pinking. Bottom hems not less than 1 inch.	1. 05	1.15

NURSE PLACEMENT SERVICE

NPS announces the following placements and assisted placements from among appointments made in various fields of public health nursing. As is our custom consent to publish these has been secured in each case from both nurse and employer.

PLACEMENTS

*Anne Poore, B.S., supervising nurse, Kansas City-Wyandotte County Health Department, Kansas City, Kans.

*Annette M. Sheehy, B.S., area nursing advisor, Atlantic Seaboard Agricultural Workers Health Association, Inc., Philadelphia, Pa.

*Arline Risdon Mansfield, B.S., M.A., area nursing advisor, Atlantic Seaboard Agricultural Workers Health Association, Inc., Philadelphia, Pa.

Bruce Hellams, nursing field representative, American Red Cross—Southeastern Area, Atlanta, Ga.

*Mary A. Westerfield, public health nurse, Dolgeville Public Health Association, Dolgeville, N.Y.

*Mrs. Mildred M. Whitaker, staff nurse, Visiting Nurse Association, Inc., Los Angeles, Calif.

*Jean Keatley, school nurse, Otto Township School District, Duke Center, Pa.

Neva P. Gaudin, industrial nurse, Pantex Ordnance Plant, Amarillo, Tex.

Glynna O. Jones, industrial nurse, Chicago Flexible Shaft Company, Chicago, Ill.

ASSISTED PLACEMENTS

*Martha Garst, staff nurse, Visiting Nurse Service of New York (formerly Henry Street Visiting Nurse Service), New York, N.Y.

*Mrs. Portia L. Conway, B.A., M.S., staff nurse, Clark County-City Health Department, Vancouver, Wash.

*The NOPHN files show that this nurse is a member.

Red Cross Nursing in Camp Communities

By FAYE MARLEY

THE RED CROSS Camp Community Emergency Nursing Service was established because of conditions created by the migration of the families of men in military service to areas where the facilities of local health departments were inadequate to meet the abnormal demands.

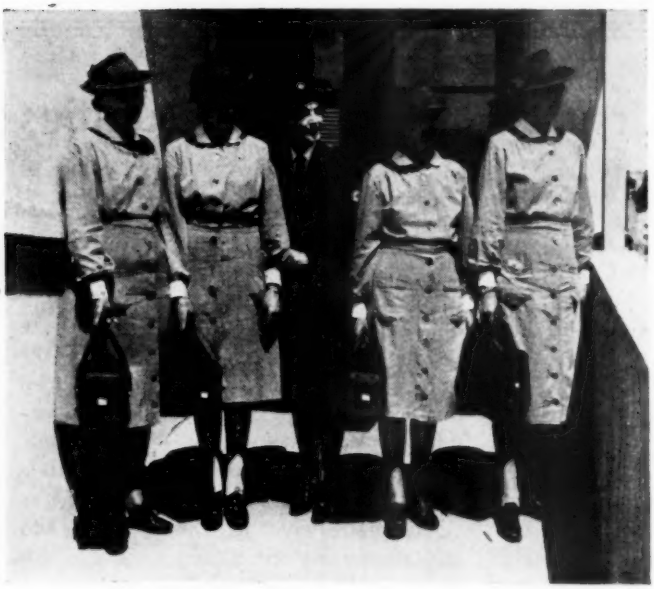
At the request of Army and Navy medical personnel and health directors, and with the cooperation of existing health agencies, the Red Cross since 1942 has set up services in areas adjacent to camps and in a few industrial cities. This was only after thorough investigations of conditions. At first the outstanding need was for bedside nursing care for those ill at home who could not be cared for in hospitals because of overcrowding. Later, when the Emergency Maternity and Infant Care program of the U. S. Children's Bureau provided hospital care, it was decided that there should also be emphasis on ante- and post-partum work, and the teaching of mothers' classes. Wherever the EMIC program is functioning, the Red Cross cooperates.

Mrs. Elsbeth H. Vaughan, assistant director, Public Health Nursing and Disaster, American Red Cross, made two extensive trips recently, one to the Pacific Area and one to the Midwest and regions in the South. "I visited some of the 52 nurses in emergency camps, and am convinced of the fact that they are filling a great need," Mrs. Vaughan said. "I am equally sure that as the wartime emergency disappears, the work can be absorbed by health departments. From the beginning of the Red Cross public health nursing services in 1912, the aim has been to demonstrate the value of such services and assure their permanence 'by ultimate transfer to public, tax-supported agencies.' "

There is nothing so inspiring in the nurse's profession as the old-fashioned ideal of service to people in isolated communities where the visit of the public health worker is accepted with gratitude and relief. Especially in these trying days when young wives are living in squalid and unsanitary conditions, not through choice, but because it is their only chance to live with their husbands and babies before the family is broken up by overseas duty, the public health nurse has an opportunity to serve. Not only is she able to help out with health needs and bedside nursing, she is able to perform the functions of a neighbor and familiar friend in an environment that is strange and at times fearful.

PUT YOURSELF in the place of a soldier's wife living in a shack on the outskirts of a large camp down South. Think of her lying alone and sick at night, listening to taps. Her baby's father may be on maneuvers or waiting for a call to overseas service. Who can she turn to except the Red Cross nurse? Her neighbors, of course, and helpful they try to be, but there is no one to inspire her confidence, to take the place of a wise mother, to represent her family doctor except the nurse.

Night after night there is a knock on the nurse's door and a call to visit someone in distress. Sometimes it is an emergency appendicitis case. Often some young mother about to go into labor calls for an ambulance to take her to the hospital. Sometimes there isn't time to get



From left to right: Mrs. Jean A. Cooper, Mrs. Grace Crayne, Katherine Laux, assistant director, Nursing Service, Vallejo; Mrs. Ruth McFarland and Mrs. Mary McAneny.

her to the hospital, and the nurse, after phoning the distant doctor, assists with the delivery.

But let Ann Rontal, a nurse in Braggs, Oklahoma, tell her own story:

"It is difficult, in a way, to choose case history stories with a human interest appeal because of the flood of human drama which is being enacted daily. None of it is startling; it will never make the headlines. The human drama which the nurse is encountering lies buried deep, so deep that perhaps the protagonists themselves are not fully conscious of it. Yet to someone interested and observant of symptoms, many little signs present themselves.

"Some are overt, there for the asking; many are covert, to be felt and experienced but not seen. The nurse is thinking in terms of the soldier couples because they are the chief actors now. Their emotions, their lives, their dreams, all the things that people strive and yearn for are being bent and twisted, maybe beyond recall. These couples clutch desperately at little whiffs of happiness here and there. It is painful to observe because one knows that for some couples these fleeting moments of happiness are but preludes to everlasting sorrow. Yet the grandeur of their courage in the face of imminent catastrophe paints letters heaven-high that out of the well of their sorrows and tears, a mighty and just cause can be fought for and won."

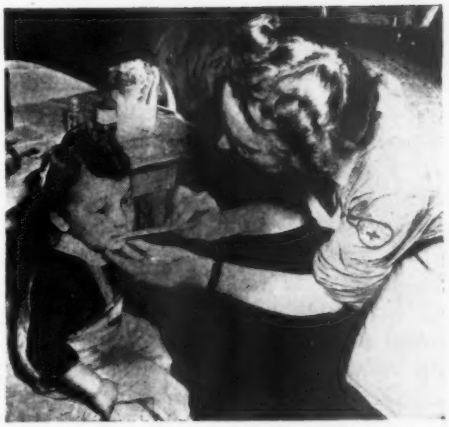
Another nurse illustrates with the following story:

"A mother and baby returned from the hospital the fourth day post-partum. The evening of the day they came home, the father was shipped out. He had planned to get an emergency furlough after she left the hospital so that he could get the meals for his wife and do the washing. They lived in one room, in which they slept, ate, and cooked. There was no running water nor kitchen sink. When the nurse went in the next morning, Mrs. T.'s eyes were red, probably from weeping most of the night—the baby had been fretful too. But as usual there was a way out."

Two little girls in the rear, themselves pregnant, literally pitched in, did the washing, took her meals, and cared for the baby. Her thanks for the care and help was really sincere. As soon as she

was able, she planned to return to her home, but although her circumstances were difficult, she said she did not regret going through this. It would have been worth it if her husband had got to see his baby only one time before he left, she said.

Another story describes a visit to the home of a young Mexican mother with her second baby. When she was told about the public health service, a happy expression spread across her face, and with tears in her eyes she turned to her little boy and said, "We thought we were all alone with Daddy gone, and now we have the Red Cross."



THE NURSES serving in these communities are dealing with a constantly changing population. These changes may occur as often as every two months, or according to the frequency of troop movements. Their work is made more difficult by inadequate housing, the crowding of families into all sorts of shelters, and the distances that must be covered in order to locate new arrivals.

Mrs. Mary Caldwell, nurse at Camp Shelby, Mississippi, covers a large area near the camp. One of her communities is called McLaurin, of which she says:

"McLaurin is a strong eighteen miles from Hattiesburg and two miles off the main road. It is directly outside Gate Seven at the extreme south of Camp Shelby. There is only one street really, and that is a continuation of the road out from Gate Seven which winds off into a sandy country lane through pine woods and practice areas for the soldiers.

"The railroad cuts through the middle of this so-called street, and once a day a train ambles along the track from Hattiesburg. There is one general store, a filling station—no, three, now—a grocery store, one fairly large restaurant with a juke box; also a beer joint, which one smells before it is seen.

"A small post office next door to the general store is kept by two little ladies, as sweet as autumn apples, and they relay to me all the news in the community. They also take any nursing calls that come in. The one and only telephone for miles around is in this weather-stained post office and the post office is closed at 6 p.m.

"There are no street lights or walks, but the cows and pigs have obligingly beaten down the weeds into somewhat irregular paths. When the moon is not shining, the white sand helps to show the way to the cabins. No place on earth is so dark at night. Since the nurse must make the first call to determine the need for a doctor, we have had plenty of opportunity to discover just how dark a dark night can be.

"The majority of the cabins are without heat and the water is centrally located; about one hydrant to forty or fifty cabins is the ratio. The toilets are pit, and except for two groups of cabins, only one toilet is apportioned to ten or twelve cabins. A water system is being installed."

Mrs. Caldwell illustrates how cooperative the chief medical administrative officer is, by telling the story of a day that began at 3 a.m.

"A young expectant father knocked at my door to tell me his very young wife was in labor. Two hours later she seemed to have progressed to the place where she needed to go to the hospital. Her physician was a Hattiesburg man, and since

the young sergeant had no car, we called the station hospital and their ambulance took the girl to the Hattiesburg hospital.

"Later in the day there were so many flu patients, some with a very high fever, that I asked for a doctor and one was given. We started out to make the rounds of the tourist camps. In one camp, there were four patients all in a row, one a very sick infant, and while we were there, a girl from another cabin came in, and fainted at the doctor's feet, the baby went into convulsions, and the mother into hysterics all at one time. How thankful I was for that medical officer. In no time at all, peace and order were restored and everyone was feeling better. This particular medical officer is a great joy."

In Hondo, Texas, the Federal Housing Project has turned over the two homes originally set aside for clinics to the Nursing Service. These offices, attractively furnished, are centrally located and therefore of help to the service. In Palacios, Texas, the service is given space in the small building housing the Gulf Health Unit, and other places have similar quarters for office work.

SHORTAGE OF housing facilities for the families of soldiers presents many serious problems. The new population group has had to be crowded, literally jammed into the existing but none too large homes in the community, and beyond that point, it is necessary to utilize every kind of cabin, sheds of all sorts and trailers. The majority of these new families are crowded into one room, a shed, or sun porch.

In the majority of cases, the rents are out of proportion to the facilities offered. Small cottages that would ordinarily rent for about $30 a month often bring $100. Sheds rent for $30 and more. It is a recognized fact that some civilians are taking this opportunity to make as much money as they can.

Captain E. and his wife live in a one-room cabin that at one time was a chicken house. Both are very young. Mrs. E. brought their new baby home from the hospital, and it was necessary for her to be in bed for one week at home. The nurse called daily to give her bedside care and bathe the baby. The Red Cross loaned her several sheets from the loan closet to supplement her meager supply. Although she is now up and about, doing her own work, she still welcomes the nurse's weekly visits, for she is always anxious to see how much the baby has gained, and has no scales.

She and hundreds of self-respecting young wives are doing their best to preserve the niceties of home in sordid and mean surroundings.

There are two classes of young mothers in the camps. First, there is the intelligent type, eager to do the right thing, who gives the best possible care to her baby. Many of these women were former school teachers, some of them were professional nurses. Second, there is the type totally lacking in ability—some of them of subnormal intelligence. "They just don't care." The visiting nurse will find their cabins in the worst possible state of disarrangement, with breakfast dishes and baby things all mixed up on cluttered tables.

Some trailers and cabins have been papered prettily and have curtains. Some of the wives have nailed heavy cardboard boxes to the wall for shelves and are making the best of the situation.

The Red Cross camp community emergency nursing services are made possible through the Jane Delano Memorial Fund. They have inspired the fullest cooperation of the medical service of the posts, the official health agencies, and the local Red Cross chapters that administer them. They have without doubt proved the need for professional nursing care and health instruction in the communities where they are functioning.

Following is a list of the services in operation since 1942:

Camp Beale, Marysville, California
Army Flying School, Chico, California

Mare Island Industrial, Vallejo, California
Fort Ord, Fort Ord Village, California
Camp Roberts, San Miguel, California
Army Air Base, Santa Ana, California
Camp Beale, Grass Valley, California
Tucson, Arizona
Camp Chaffee, Fort Smith, Arkansas
Camp Blanding, Starke, Florida
Fort Benning, Columbus, Georgia
Camps Beauregard, Livingston, and Claiborne, Alexandria, Louisiana
Camp Shelby, Hattiesburg, Mississippi
Camp Crowder, Neosho, Missouri
Fort Leonard Wood, Crocker, Missouri
Camp LeJeune and Camp Davis, Jacksonville, North Carolina
Camp White, Medford, Oregon
Fort Sill, Lawton, Oklahoma
Camp Gruber, Muskogee, Oklahoma
Navy Ship Building Industry, Bremerton, Washington
Fort George Wright, Geiger Field Air Base, and Farragut Naval Training Station, Spokane, Washington
Army Air Base, Ephrata, Washington
Camp Howze, Gainesville, Texas
Camp Wolters, Mineral Wells, Texas
Camp Bowie, Brownwood, Texas
U. S. Army Air Force, Navigation School, Hondo, Texas
Camp Hulen, Bay City, Texas

FROM A PUBLIC HEALTH NURSE IN FRANCE

THE first mail call we've had in over two weeks came yesterday and your welcome letter was one of an accumulation of twenty letters I was lucky enough to get.

We're in France now, living in tents in a small field bordered by hedgerows. Everything is set up field army style. The French peasant type of women and throngs of children—many with obvious Aryan features wander through our field from morning to night carrying gunny sacks on their backs in which they collect the various and sundry donations we give them. They love our Army "K" rations, clothes, and American cigarettes. We give them everything we can possibly spare—or manage to get along without. Soap is a particularly rare treat to them. These poor French people are so thin, malnourished, and wartorn, it is pathetic. They smile from ear to ear every time they see an American—no doubt about their genuinely appreciating their liberators!

The roads are only "cleared" to the hedgerows and in specific small plainly marked areas, so we have to be careful not to roam too far afield, as we see dead cattle lying around where they have either bumped into mines or set off booby traps.

I have ridden through some towns in which there has been heavy bombardment and to say they are a mess is putting it mildly—they are completely demolished! You couldn't believe how much destruction there has been unless you could see it with your own eyes. It's really appalling! Just a few weeks ago this territory was headline war news—though security regulations do not permit me to mention the names of the towns in this section at the present time.

We had quite an experience coming to France. The English Channel was so rough we had to be anchored about ten land miles out from shore four days before we could transfer from the ship on to small landing crafts which took us up to the beach-head. The high ranking officers were given staterooms, but they only stayed in them one night because they found them full of vermin—so they took "pot-luck" with the rest of the troops after that. We slept either on the floor or in hammocks—in the hot, smelly "hold" of the ship or else on the open decks—which were the places of choice.

Every place one lives has its drawbacks, I suppose, and the chief abomination of our present field life is the "yellow jacket" menace. They are terrific! They swarm all over our food and put up a terrific defensive, so it's almost worth your life to take a mouthful of food without getting it "avec" live "yellow jacket" compote. And do they sting—my stars!

(Continued on page 540)

Guidance for the Nurse in Industry

I. The State Industrial Nurse Consultant

By JOAN Y. ZIANO, R.N.

THE MANY HEALTH services available through a state public health department are still not being utilized to the fullest extent by individuals, medical and nursing professions, schools, industries, and lay organizations. This is particularly true in regard to health services for industrial medical departments. Such health services are of inestimable value to the new as well as to the experienced nurse in industry engaged in the development of a health program in her plant and the coordination of such services with the community as a whole. Since most of the states have a somewhat similar organizational structure, a brief description of the Illinois State Department of Public Health will serve as an illustration of the various activities available through a state department of health.

The Illinois Department of Public Health under the able direction and supervision of Dr. Roland R. Cross, director of public health, is comprised of 15 divisions, which carry on the various public health activities in the state.

The 101 counties, exclusive of Cook County, are divided into 15 public health districts and each is under the supervision of a full-time medical health superintendent who has been assigned nursing, engineering, dental, and other necessary personnel. These districts function only in areas not served by local full-time health departments.

The State Department of Public Health has maintained, since the advent of war, with local cooperation, full-time "defense zone health departments" in 15 counties. These are deriving the benefits of a continuous whole-time local community health service, rendered by the state on a war emergency basis.

Under the new Searcy-Clabaugh legislation it is now possible for any county in Illinois to establish and maintain under home rule its own permanent and full-time county health department. The "district" plan of organization is being discarded as rapidly as county health departments can be developed. Two counties, Lawrence and Morgan, have already taken advantage of this law.

In addition to the district and county health departments there are also 10 full-time municipal health departments in Illinois.

Consultant service is available through the various divisions of the State Department of Public Health upon request from municipal, county, or district health departments.

The Division of Industrial Hygiene in the State of Illinois has been established since 1936 and works in cooperation with the other divisions to bring to industry all public health activities of the State Department of Public Health.

The personnel at the present time consists of a medical director who is also chief of the Division of Industrial Hygiene, an industrial hygiene physician, four industrial hygiene engineers, two chemists, one dental hygiene consultant, one industrial nursing consultant, a nutrition consultant (through the Division of Maternal

and Child Hygiene), and two secretaries.

The nursing consultant was assigned to the Division of Industrial Hygiene from the staff of the Division of Public Health Nursing in February 1942.

IN ORDER to evaluate the problems pertaining to health as related to industrial nursing a survey of the situation presented in an individual state is a necessity. Each state must of necessity be considered as an individual entity, presenting problems peculiar to the section and region in which it is situated and the laws by which it is governed.

The compilation of a roster of the industries employing nurses and the names of the nurses employed therein is among one of the first necessary tasks. The sources of information are various. State, district, county, and municipal health departments can be utilized. Active industrial nursing organizations are most cooperative in supplying this information.

Illinois has at present approximately 1,500 registered nurses employed in industry.

Personal contact is being made with individual nurses by the industrial nursing consultant as rapidly as possible. Because of the large number of industrial nurses involved, requests are given preference. Requests are varied, coming from municipal, county, and district health departments or directly to the Division of Industrial Hygiene from management, industrial physicians, and industrial nurses.

The initial contact of the nurse consultant is usually made through management, in most cases through the personnel manager; or in plants employing one, through the plant medical director. The preliminary contact establishes a certain rapport with management and the industrial physicians and nurses.

The services available to industry, which are without charge, through the various divisions of the State Department of Public Health, Springfield, Illinois, are as follows:

The municipal, county, and district health departments have much to offer in the correlation of a health program in the plant with that of the community through the Division of Local Health Administration and the Division of Public Health Nursing.

The Division of Venereal Disease Control maintains a consultant service and a number of venereal disease clinics throughout the state. Educational material is available to the plant upon request.

Through the Division of Maternal and Child Hygiene, consultant service in matters pertaining to maternity and child care can be obtained. The nutrition consultant working with the State Nutrition Committee is available for the appraisal of existing plant cafeterias and in-plant feeding problems and for plants contemplating the institution of plant feeding facilities.

The Division of Tuberculosis Control has transferred to the Division of Industrial Hygiene a mobile 35-millimeter X-ray unit which can be obtained by industry for chest X-raying of workers on a voluntary basis, with the cooperation of the county medical society, the local county tuberculosis associations, and sanatorium boards. A similar service is available in Chicago through the Municipal Tuberculosis Sanitarium.

The Division of Public Health Instruction has a wealth of health educational literature that can be obtained upon request. Also, moving picture films on various health subjects are available and loaned to industries throughout the state. This division is now in the process of training health educators to be assigned to full-time county health departments. They will be available to work with industry.

The service of a dental consultant is available to industry for studying oral manifestations of occupational exposure. Dental health education is also stressed.

The Division of Vital Statistics can be of great value to the industrial medical

department for statistical data concerning incidence of disease in any given community or area of the state.

The Division of Laboratories examines routine specimens submitted to its various divisions, bacteriology, serology, and typhoid, and dispenses biologics free of charge. The coordinating laboratory inspects and approves industrial and other laboratories to do premarital blood tests and other examinations.

The Division of Sanitary Engineering is equipped to render services concerning potability of drinking water, construction of toilet and other sanitary facilities, and for the study of potential health hazards due to improper sanitation both in the community and industrial establishments.

The Division of Industrial Hygiene of the State Department of Public Health is an official, fact-finding, advisory agency of the state government, established to assist industry and labor, and all those directly involved in studying and controlling the problems of industrial hygiene and sanitation. The following services of the Division are offered at no cost to industry:

1. *Medical*
   - Evaluation of environmental exposures
   - Diagnostic aid to medical profession
   - Maintenance of an occupational disease clinic for case study
   - Formulating industrial medical programs
2. *Dental*
   - Assisting in the formulation and promotion of industrial dental programs
   - Recommendations for improving industrial dental services
   - Study of oral manifestations of occupational disease
3. *Engineering*
   - Plant surveys and studies of industrial processes and operations
   - Collection of industrial atmospheric contaminants
   - Recommendations for methods of control
   - Information and designs of industrial exhaust systems
4. *Chemical*
   - Complete laboratory facilities for analyses of materials and air samples
   - Research in methods of collection and determination of atmospheric contaminants
5. *Nursing*
   - Assistance in setting up a health program in industry
   - Clearing house for industrial nursing information
   - Up-to-date industrial hygiene (medical and nursing) literature, education health literature, and posters are available for distribution

The next objective after the preliminary contact of the industrial nurse consultant is the appraisal and evaluation of the existing nursing program and assistance, if such is needed, in improvement of service.

It would be indeed difficult to attempt to describe the full content of a visit. Each visit develops into an individual conference and as such has to be handled accordingly.

ONE OF THE present needs of the industrial nurse seems to be for up-to-date, pertinent literature regarding the many phases of industrial medicine and hygiene, industrial hygiene nursing, and adult public health. The nurses welcome material and any assistance that is available.

Proper medical supervision is another necessity for the industrial nurse. There are still far too few plant medical departments in which the nurses are operating under written standing orders, signed, dated, and reviewed from time to time by the physician in charge.

Assistance with the various records necessary in a plant medical department and an adequate recording system is also requested. Adequate recording protects both the worker and the employer. Records are valueless to industry unless they stimulate an interest in the program that is being carried out and unless through them existing conditions are improved. Adequate records keep management informed of the nurse's activities and serve as a guide in the prevention and control of accidents and illness, both occupational and non-occupational, resulting from causes which can be prevented and controlled.

A successful health education program requires a knowledge and the use of existing community resources. Health condi-

tions and findings in a community are also reflected throughout the plant. In the plant a knowledge of the processes used and the potential health exposures from such processes is a necessity, along with the knowledge of where engineering consultation of such health hazards can be obtained by industry.

It is most important to the future of industrial nursing that professional affiliations be maintained—namely, membership in alumnæ, district, state, and American Nurses Association, the local industrial nurses group, the American Association of Industrial Nurses, and the National Organization for Public Health Nursing.

In accordance with the Nurse Practice Act, it is also important that industrial nurses maintain registration in their state of employment.

At present in Illinois industrial nurses throughout the state are becoming interested in the organization of local industrial nurses' groups in the districts of the recently formed industrial nursing section of the Illinois State Nurses Association. This will lead to active attendance and participation in the professional nursing organizations.

Conferences on the "Health of the Worker" have been held in strategic industrial areas of the state, under the auspices of the Illinois State Medical Society, the Illinois Manufacturers Association, and the Illinois Department of Public Health, for management, industrial physicians and nurses, and other interested health and welfare agencies.

Industrial nursing courses are being given by two leading universities in Illinois and each course has been well attended. Many of the industrial nurses are also enrolled in other public health nursing courses at these universities.

In conclusion, industrial nursing, as any other branch of nursing, involves attitudes and personalities. Attitudes involve an age-old problem, namely, that of approach. An understanding of the industrial nurse and the problems facing her, with a sincere desire to assist, brings about an active response. On the other hand, attempts to force opinions upon her bring about defensive attitudes which only tend to further the retardation of the industrial nurse in seeking equal opportunities now enjoyed by other branches of nursing. The industrial nurse has been most receptive to suggestions given in her specialty from an official agency at the state level and has evidenced much and varied interest in the subject of the "Health of the Worker" and the development of a sound health program in industry.

II. The Nurse Educator

By ELIZABETH M. HANSON, R.N.

GUIDANCE FOR the nurse in industry is pertinent at this time. While nursing in industry is not new, we have been experiencing a rapid development in this field. That is true here, as elsewhere, in Buffalo, a large industrial center.

The University of Buffalo and the Niagara Falls Frontier Industrial Nurses' Club have shared, and are sharing, an experiment in meeting the needs of the industrial nurses in this area. We of the University were made aware of this need of the industrial nurse, a need insistent of being heard. And so a joint venture was begun; on the one side a club group of 112 nurses in industry, most of whom had entered this field directly from general

duty in hospitals or from private duty; on the other hand the University of Buffalo sharing by assuming leadership in furthering actual preparation of the nurse for her job in industry.

During the fall of 1942 we communicated with universities already giving courses in industrial nursing, with outstanding nurses in industry, with NOPHN, and with the New York State Industrial Commission, stating our problem and inviting comment. Subsequently, in the spring semester, 1943, the University offered a two-semester-hour course in industrial nursing. The course was designed to give consideration to the administrative, medical, and nursing aspects, and participating in the teaching were two outstanding leaders in industry, an administrator and a physician. The nursing aspect was carried by myself.

Seventy nurses enrolled in this first course. The response, so stimulating in its sincerity, called for further consideration. A plan was then made to increase the offering to include a two-semester course.

In the meantime we have been made aware of a developing attitude in this group of an increasing grasp of the meaning of preparation for one's job. Occasionally a class member would come in stating that she wanted to go into general public health nursing and wished to enroll in additional courses. One did resign her position and came in for full-time study. Obviously they were responding to certain challenges in the academic environment, in study, and in contacts with other workers in like positions.

It followed that out of our relationship certain objectives were taking form, notably that preparation for the job is vital in rendering an adequate nursing service. One outcome of this enlarging perspective is the establishment of a program in industrial nursing comparable to the one in public health nursing and covering completion of 38 semester hours of study and of field experience.

Since one cannot render an adequate service to a segment of the population, or to a segment of a person's life apart from the whole, the program has been set up with consideration of the fact that the individual worker is a member of a family and of a community, that his "day" on the job is a part of the total 24-hour day in his life. Therefore family health service and welfare in relation to his physical, mental, and emotional life have been included. Field experience for enrichment of this preparation of the industrial nurse, within our reach, will be utilized. We hope to place increasing emphasis upon this aspect as opportunities develop.

Nursing in industry is public health nursing with such additional activity as the special field calls for, and therefore the program of preparation includes such courses as Principles of Public Health Nursing, Industrial Nursing, Preventive Medicine, Public Health Administration, Nutrition, Teaching in Public Health Nursing and a number of others to a total of 38 semester hours of credit, comparable to the total requirement of the general program for public health nursing.

The two courses, Industrial Nursing and Emergency Nursing in Illness and Industrial Accidents, are peculiar to nursing in industry; the other courses are common to general public health nursing.

Understandable is the general objective in industry, namely, maximum production at minimum cost of the commodity for which the plant has been set up. Industry is a commercial business, not necessarily humanitarian. It values however a health service which promotes its business.

On the other hand the objective of the health program in industry is optimum health of the worker eventuating in maximum production in the industry. It is by its very nature humane. An adequately functioning health program not only satisfies industry but tends to increase the quality of life, one of the greatest needs of today. It follows, then, that the health program personnel must have special and

definite preparation for the job. A university in the same area which includes a school of nursing is in a strategic position to help.

Comments made by members of our class in Industrial Nursing indicate that the members are becoming public-health-nursing minded. A special assignment this past semester, study of the adequacy of existing standing orders, brought satisfying outcomes.

Most of our industrial nurses have been listing their functions as "assisting the physician," "assisting personnel and safety managers," and giving first aid. Upon entering industry the nurse is taught how to assist, as mentioned, how and what first aid to render, and she gains thereby a certain security in those activities. Some have become rather complacent as a consequence. However, we are beginning to think in terms of participation in the health program which is far more meaningful, and it is understandable that this calls for definite qualifications. I have felt in the nurses a growing consciousness of the potentialities in industrial nursing where acceptance of established patterns will not be so satisfying, but where participation in developing a fuller health service will be possible. Also, replacing the sentiment that "I am giving a service second to none," there is a beginning feeling that "I should like to have the state industrial nursing consultant visit me and help me evaluate my service." Our class discussions turn in this direction.

We are just now in the process of further defining our needs and of working out the means for meeting those needs.

III. The Industrial Nurse Supervisor

By ALICE J. PETRINIC, R.N.

TODAY WE ARE all faced with the problem of critical shortages, not only in obtaining qualified personnel but also in obtaining equipment and supplies. The past two and a half years have shown medical departments the need for utilizing what personnel they may have to the best advantage in order to give proper medical care to employees, as well as the need for substituting for materials and supplies which have disappeared from the markets. This has meant many alterations in our every day procedures.

We are all striving toward the ideal functions in industrial nursing, such as participation in preventive health programs, safety education, sanitation, personal hygiene, rehabilitation, and the use of community resources. However, since we must live in the present, let us get down to fundamentals. Health education programs must be streamlined to conserve manpower. This can be accomplished through such devices as articles in the plant news, health posters displayed on bulletin boards, and even by the nurse discussing methods of better health with employees while bandaging a finger or giving more lengthy treatments.

IN WHAT WAYS can utilization of nursing personnel be most effectively accomplished? In a smaller plant employing one or more nurses on a shift, the nurse does not necessarily devote all of her time in rendering medical services to employees. Many times she is called upon to perform duties of a switchboard operator, time clerk, or personnel interviewer. Management asks her to take on many non-

professional activities, in order to utilize what seems to be her excess time. These additional non-professional functions have been assigned to her simply because she has not made an effort to prove to her management just what she has accomplished or can accomplish in the way of minimizing industrial and non-industrial injuries, decreasing lost time compensation cases, and lowering absenteeism. The best values of the service she can render are wasted unless she is utilized in a program of this nature, planning for the health education and safety of the employees with emphasis on accident prevention, being on the lookout for plant hazards, and other activities for which her training fits her. Many smaller plants may not have departments assigned to carry out these functions, but they can use the services of their state division of industrial hygiene to help correct the hazards which the nurse may point out.

I have mentioned what the smaller plant can do to utilize its nursing personnel. Now let us compare this with what a larger plant with more than one dispensary can do. A nurse can be invaluable to the doctor by screening the cases and referring to him only those patients who need his consultation; by referring employees to their own family physicians for non-occupational conditions; and by rendering prompt and efficient nursing care to all industrial injuries and illnesses and such care of non-industrial injuries and illnesses as indicated.

Another way in which she could conserve the doctor's time might be by assisting with routine medical examinations and recording the findings of height, weight, near and far vision, and blood pressure. Any skin conditions, varicosities, hernias, and abnormalities could be brought to the attention of the physician, thereby successfully eliminating unnecessary lost time and permitting the doctor to utilize more time in classifying prospective employees. She can, under supervision of a reputable ophthalmologist, remove foreign bodies from the eye. She can remove sutures, assist in applying casts, prepare employees' injuries for the doctor's attention, and assist with minor surgical operations. In addition to these duties, the ordering of supplies and the responsibilities involved in the maintenance of departmental equipment may be assigned to the supervising nurse.

These alterations in procedure to fit present-day needs will undoubtedly relieve the doctor of many unnecessary duties, and as a result, more time will be allotted to rendering more efficient and prompt medical services.

We have discussed the ability of the nurse to help in conserving the doctor's time. What are methods in which her own time may be conserved? It has been proven that, under adequate supervision, many duties previously performed by nurses, in hospitals as well as in industry, can be successfully accomplished by non-professional personnel. For example, clerical work may be minimized by employing clerks for filing and keeping of records. The clerks' duties may include filing of X-rays, typing out various hospital forms, maintaining stationery supplies, and telephoning outside specialists for consultation.

At the present time, well-trained technicians are extremely hard to find; fortunately X-ray and some simple laboratory procedures can be taught, in a relatively short time, to nurses who are interested and adaptable to this type of work. A nurse with such training could be utilized elsewhere when the demands of her time in this specialized activity are light. Developing of X-rays and the general duties involved in the X-ray dark room, as well as the laboratory, may be assigned to a non-professional.

Another important factor in conserving time and energy is eliminating confusion and this can be successfully achieved by dividing the physical layout

of the department into three separate units, namely, treatment, physical examination, and clerical.

In the larger plants, special departments are organized to perform specific duties and this tends to bring about a friendlier attitude between management and labor. The personnel department may handle absenteeism and act in an advisory capacity for personnel problems. The safety department may stress prevention of accidents through a safety program. The compensation department may handle the details related to lost-time occupational injuries, thereby eliminating additional non-professional activities on the part of the nurse and also providing the employee with better service and more reliable information.

We must not overlook the importance of written standing orders as a protection to the nurse, worker and management. These orders should be available and easily accessible at all times, so that she may refer to them whenever in doubt and follow the procedure designed for her guidance, especially when she is working alone. Time is again saved by knowing what to do and whom to consult or notify at the right time.

How does control of supplies fit into the picture of effective utilization of nurses' time? Few nurses have had experience in purchasing supplies and they do not realize that care must be exercised to eliminate the possibility of obtaining an inferior product. A trade name should not be the basis on which goods are purchased. Some of the larger plants have set up a central supply department for the purpose of obtaining medical supplies at a minimum cost and for establishing a standardized treatment. A centralized system of this kind is very helpful to the nurse, for the duties involved in dealing with vendors, comparing price lists, and in substituting drugs and materials where necessary, can be turned over completely to a person qualified in this line. A medical supply list should be furnished each dispensary and, to eliminate confusion in requisitioning supplies, measurements and quantities may be listed with each item. Each dispensary is assigned a certain day for requisitioning and in this way, prompt deliveries are obtained. Much time is conserved by nurses in this type of control system, with the final result that her own time is utilized in doing her specific job more efficiently and intelligently.

With all these suggestions in mind, let us be reminded of our fundamental objective in this war effort, mainly the conservation of manpower through health education and best of medical care.

From a symposium, "Guidance for the Nurse in Industry," presented at the Industrial Nursing Section Meeting, Biennial Convention, Buffalo, New York, June 6, 1944.

IMPROVISED EQUIPMENT HANDBOOK

SEVERAL MONTHS ago, as you may remember, there were notices in PUBLIC HEALTH NURSING and in the *American Journal of Nursing* requesting nurses to send to JONAS suggestions for apparatus to assist handicapped children and adults in their functional activities. Nurses all over the country were interested and many suggestions were received at JONAS. Margaret Arey, then assistant consultant in orthopedic nursing for the NOPHN, put these suggestions together. To her fell the task of selecting the most generally useful apparatus of the many interesting articles suggested for inclusion in her new handbook, Improvised Equipment for the Physically Handicapped.*

This high chair has a rounded block attached to the front of the seat to prevent the child from slipping out of the chair and to keep her legs abducted. The same type of block might be used in a lower nursery chair. Note the foot support.

The introduction gives an idea of the handbook: "The articles illustrated can be constructed in the home or in the hospital's carpenter shop with a small outlay of time and money. They are first of all designed to be useful, but attention is given to the attractiveness of the completed article. . . . Imagination and ingenuity combined with time and effort are needed to construct from raw material any article to serve human needs. The foremost requirement, however, is an earnest, intelligent desire to help the patient toward his goal of physical independence."

*Available free of charge from the Joint Orthopedic Nursing Advisory Service, 1790 Broadway, New York 19, New York.

DID YOU KNOW THAT—

6 percent of the nurses serving in the Army and Navy Nurse Corps are public health nurses?

64 percent of all public health nursing agencies in the U.S. employ only one nurse, less than one percent employ 50 or more?

845 U.S. counties have no public health nursing service?

These and many other new and interesting facts are presented in *Facts about Nursing, 1944*, published by Nursing Information Bureau, 1790 Broadway, New York 19, N.Y. Copies 25 cents.

Reviews and Book Notes

THE PUBLIC HEALTH NURSE IN THE COMMUNITY

By Clara B. Rue, R.N., B.S. 283 pp. W. B. Saunders Company, Philadelphia, 1944. $2.50.

This book presents an up-to-date and inclusive overall view of public health nursing today. The history in the first three chapters is short and serves to illume and clarify the present situation and indicate some of the future trends.

Two sentences in Chapter 4 are worth noting: "A community's personality is the outgrowth of its developmental history" and "Such basic understanding (of the community) is as indispensable to the public health nurse as light is to the artist."

Three full chapters discuss cooperation between various groups. Had principles of cooperation applicable to all groups been given, it would have obviated the necessity for such a lengthy discussion and suggested tangible means of application and criteria for evaluation of existing situations. The fine material in these chapters has a tendency to become lost in words. One might also wish for a different emphasis than the one given by the author's frequent use of the word *should*. A little careful editing could have helped in a number of places.

The discussion of various programs is inclusive, well organized, and displays the author's familiarity with the subject.

Few subjects related to public health nursing are omitted. A chapter on future professional planning as it affects the public health nurse in the community might have been included, covering some of the following: use of non-professional personnel; the place of nursing in rapidly developing insurance plans; utilization of the war-stimulated lay interest in the nursing profession as evidenced by the Bolton Bill and the Red Cross Nurse's Aides; future of government financial support of schools of nursing; needs of nurses returning from military service; utilization of the psychological moment in health highlighted by conditions revealed by the draft and problems precipitated by the war.

This book makes a worth-while contribution to our professional literature and may be used to good advantage as reference or text. Because its organizational form follows that of the *Public Health Nursing Curriculum Guide,* they lend themselves well to being used together if this is desired.

ELEANOR PALMQUIST, R.N.
Nashville, Tenn.

ORGANIZING TO HELP THE HANDICAPPED: A BRIEF GUIDE FOR VOLUNTARY ASSOCIATIONS FOR THE CRIPPLED

By T. Arthur Turner. 165 pp. National Society for Crippled Children, Elyria, Ohio, 1944. Cloth, $1 postpaid; paper, 50 cents postpaid.

In Chapter XIII, on publicity, the author of this book defines news as anything that is interesting and timely. On the basis of this definition *Organizing to Help the Handicapped* is "news." It would seem that this book is presented at an opportune moment since practically every agency in the country is involved in an "all-out" effort to assist the physically handicapped. The book contains much food for thought and should be read carefully by all personnel interested in any phase of rehabilitation. The author writes discerningly of problems encountered in this field. His analysis of the responsibilities of agencies functioning on federal, state, and local levels should clarify the confusion which occasionally exists.

Of particular interest to this reviewer were the four chapters on special projects which covered: (1) summer camps (2) the

sheltered and homebound (3) employment of the handicapped and (4) community health and the prevention of handicaps.

The public health nurse is mentioned frequently throughout the book. In Mr. Turner's opinion she plays an important role in any program devoted to the care of the handicapped. The book should be made accessible to all nurses, especially those associated with programs for crippled children.

MARY MACDONALD, R.N.
Boston, Mass.

MEDICAL CARE OF THE DISCHARGED HOSPITAL PATIENT

By Frode Jensen, M.D., H. G. Weiskotten, M.D., and Margaret A. Thomas, M.A. (Oxon.) 94 pp. The Commonwealth Fund, New York, 1944. $1.

This is a report of an experiment undertaken by the Syracuse University College of Medicine involving 902 patients discharged from the medical wards of the University Hospital from July 1940 to February 1942. The faculty had believed that medical education was becoming too institutionalized and that physicians, as well as others, were stressing the disease of the individual. Not enough emphasis had been placed on the economic, social, and environmental factors which might have an effect on the patient's recovery from illness. The study brought to light that 90 percent of the costs for hospital care on the medical wards had been spent in caring for the chronically ill patients. Only a third of the discharged cases had "satisfactory" medical care after leaving the hospital. Many of the patients had several hospital illnesses. It was concluded that the economic, social, and emotional life of the individual was closely allied with his health. An extramural resident physician was added to the medical staff of the University Hospital. This well qualified physician acted as an instructor in the Medical School and as a family physician to those discharged from the hospital and in need of medical care at home. Ambulatory patients were referred to the Syracuse Free Dispensary. When a patient had his own family physician, the extramural resident consulted with him about the care of his patient. Unfortunately this interesting experiment was interrupted by the demands of the military for physicians. However, it is hoped this service will be resumed because, to quote the authors, "There is no doubt that the provision of medical care in the home by the Extramural Resident, who had known the patient during his hospital stay and who acted in every sense as his family physician, prolonged the benefits of the hospital stay and gave the patient a sense of security which had beneficial effects on his health."

This book is thought provoking for nurses who see for their patients an integrated service in the hospital, out-patient department, and home, utilizing the necessary medical, nursing, and social resources. It is, however, disappointing that the role of the public health nurse in improving continuity of care was given so little emphasis.

GRACE A. DAY, R.N.
Brooklyn, N.Y.

TO LIVE IN HEALTH

By R. Will Burnett. 332 pp. Silver Burdett Company, New York, 1944. $1.96.

The author's approach to his subject is through presentation of hazards to health and the elementary physiological facts significant in these hazards. He is consistent in maintaining this approach although some chapter titles such as What Does Good Health Involve? suggest a more positive viewpoint.

Content is organized to give the overall national health problems, first generalized, then by age groups. This interpreted statistical material is followed by a review of elementary physiology as it is affected by hazards. The importance of health problems is expanded under headings of communicable and non-communicable disease, mental hygiene, food and health, and accident prevention and treatment. The final chapter reviews programs and

plans for more equable distribution of medical services in the United States.

The format of the book is attractive; statistical material is presented in formal charts and modified pictographs; illustrations are clear and well selected though not always adequately labeled. Covering such a broad scope in small space and in simple didactic style has naturally resulted in some misleading generalizations. The author also reflects a moralistic attitude, especially on the venereal diseases. References for further reading are included for lay persons. The book seems to be planned for use with high school students.

DOROTHY WILSON, R.N.
New York, N.Y.

NURSING PRACTICES IN INDUSTRY

By Olive M. Whitlock, Victoria M. Trasko, and F. Ruth Kahl. 70 pp. Public Health Bulletin No. 283. Industrial Hygiene Division, Bureau of State Services, Federal Security Agency, U. S. Public Health Service, 1944. Write Superintendent of Documents, Government Printing Office, Washington 25, D.C. 5 cents.

This booklet is an interpretive and statistical analysis of the report of the Committee to Study the Duties of Nurses in Industry of the Public Health Nursing Section of the American Public Health Association. It presents a complete and very timely picture of industrial nursing and industrial nurses and its concise organization of information makes this bulletin very useful for all who are interested in nursing in industry. The original study was one of outstanding importance. *Nursing Practices in Industry* does more than make this important material widely available; in itself it is a significant contribution to the advancement of industrial nursing.

WINIFRED HARDIMAN, R.N.
Hartford, Conn.

RECENT PUBLICATIONS AND CURRENT PERIODICALS

MENTAL HYGIENE

PSYCHOANALYSIS TODAY: THE MODERN APPROACH TO HUMAN PROBLEMS. Edited by Sandor Lorand, M.D. International University Press, 227 West 13 Street, New York, 1944. 404 pp. $6.

NUTRITION

SCIENCE OF NUTRITION. By Henry C. Sherman. Columbia University Press, New York, 1943. 253 pp. $2.75.

APPLIED DIETETICS: THE PLANNING AND TEACHING OF NORMAL AND THERAPEUTIC DIETS. By Frances Stern. Williams & Wilkins Company, Baltimore, 1943. 2nd edition. 265 pp. $4.

EYE HEALTH

OPEN LETTER TO MY NEWLY BLINDED FRIEND. By Joseph F. Clunk. U. S. Office of Education, Federal Security Agency, 1944. 32 pp. Write Superintendent of Documents, Government Printing Office, Washington 25, D.C. 10 cents.

A primer for the personal adjustment of newly blinded persons.

INDUSTRIAL

BRITISH POLICIES AND METHODS IN EMPLOYING WOMEN IN WARTIME. By Janet M. Hooks. Women's Bureau Bulletin 200, U. S. Department of Labor, 1944. 44 pp. Write Superintendent of Documents, Government Printing Office, Washington 25, D.C. 10 cents.

THE INDUSTRIAL NURSE AND THE WOMAN WORKER. By Jennie Mohr. Women's Bureau Special Bulletin No. 19, U. S. Department of Labor, 1944. 47 pp. Write Superintendent of Documents, Government Printing Office, Washington 25, D.C. 10 cents.

GENERAL READING

NATIONAL SURVEY OF THE HIGHER EDUCATION OF NEGROES. U. S. Office of Education, Federal Security Agency, 1942. Write Superintendent of Documents, Government Printing Office, Washington 25, D.C.

Vol. I, Misc. No. 6—Socio-Economic Approach to Educational Problems. By Ina Corinne Brown. 166 pp. 40 cents.

Vol. II, Misc. No. 6—General Studies of Colleges for Negroes. 129 pp. 30 cents.

Vol. III, Misc. No. 6—Intensive Study of Selected Colleges for Negroes. By Lloyd E. Blauch and Martin D. Jenkins. 125 pp. 30 cents.

AMERICAN ILLUSTRATED MEDICAL DICTIONARY. By W. A. Newman Dorland, A.M., M.D., F.A.C.S., with the collaboration of E. C. L.

Miller, M.D. W. B. Saunders Company, Philadelphia, 1944. 20th edition, revised. 1668 pp. Plain, $7; thumb indexed, $7.50.

SCHOOL HEALTH

YOUR SHARE IN A BILLION DOLLARS. Legislative and Relations Division, National Education Association of the United States, 1201 Sixteenth Street, N.W., Washington 6, D.C., 1944. 16 pp. Free.

About pending Congressional legislation which will make surplus war property suitable for educational use available to schools and colleges.

DENTAL HEALTH

FACTS ABOUT TEETH and THEIR CARE. National Dental Hygiene Association, 934 Shoreham Building, Washington 5, D.C., 1944. 17 pp. Single copies 10 cents.

Basic data in writing or speaking on dental subjects and for preparation or analysis of teaching units for school curricula.

SCHOOLS AIM at HIGH DENTAL FITNESS GOAL. *School Management, Administration, Equipment, Maintenance.*, School Management, Inc., 52 Vanderbilt Avenue, New York 17, N.Y., May 1944. p. 314. 20 cents.

DENTAL CARIES: A SERIOUS HEALTH PROBLEM. By Frances Krasnow, Ph.D. *The Journal of School Health,* American School Health Association, 3335 Main Street, Buffalo 14, N.Y., December 1943. p. 239. 25 cents.

Control of dental caries in school children, based on the experience of the Guggenheim Dental Clinic, New York City.

COMMUNICABLE DISEASE

ONE HUNDRED YEARS OF POLIO. By Don W. Gudakunst, M.D. *The Journal of School Health,* American School Health Association, 3335 Main Street, Buffalo 14, N.Y., May 1944. p. 109. 25 cents.

ALLERGY

KNOW YOUR HAY FEVER. A. P. Sperling, Ph.D., and Arthur B. Berresford, M.D. Frederick Fell, Inc., 386 Fourth Avenue, New York, N.Y., 1943. 241 pp. $2.

PRIMER OF ALLERGY. By Warren T. Vaughan, M.D. C. V. Mosby Company, St. Louis, Mo., 1943. Second edition. 176 pp. $1.75.

Designed for reading by the layman. Written in simple form.

TUBERCULOSIS

WHAT YOU SHOULD KNOW ABOUT TUBERCULOSIS —THE PATIENT'S QUESTIONS ANSWERED. National Tuberculosis Association, 1790 Broadway, New York 19, N.Y., October 1943. Text completely rewritten. 24 pp. To obtain, consult your state or local tuberculosis association.

This pamphlet, written in simple, nontechnical language, is intended for the sanatorium patient and for his family's information.

NURSING EDUCATION

A SURVEY OF COURSES IN SUPERVISION IN COLLEGES AND UNIVERSITIES OFFERING AN APPROVED PROGRAM OF STUDY IN PUBLIC HEALTH NURSING, 1941-1942. By Winifred Devlin, R.N., B.S. Catholic University of America Press, Washington, D.C., 1943. 33 pp. $1.

From a Nurse in France

(Continued from page 527)

Our arms are covered with big red bites—the areas become swollen tight and shiney and do they throb!

It's paradoxical, but the closer one gets to combat areas, the less one hears about the war news. We did hear though, that Paris was liberated and of course, everyone wanted to celebrate! It would be wonderful if we had a portable radio, so we could keep abreast of the news and hear music once in a while.

I'm wondering if you could give me any information about the allied postwar public health nursing plans *overseas*. I am becoming more and more interested in staying over here and I can't find anybody who can tell me how to get such information or how one could stay overseas and get mustered out of the Army to get into such work. Could you help me?

Oh, how we miss the fresh vegetables —and fruit—real eggs—milk and ice cream! Nevertheless, we're in good health and really enjoying our experiences overseas. I wouldn't trade my Army experiences for a million dollars!

LIEUTENANT MARION PLANSKI
U. S. ARMY NURSE CORPS

NOTES FROM THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

Ruth M. Scott

INDUSTRIAL STAFF CHANGE

With very great regret NOPHN announces that Heide L. Henriksen has returned to her home in Minneapolis, Minnesota, and a new appointment as industrial nursing consultant in the Minnesota Department of Health, Division of Public Health Nursing. In this connection, Miss Henriksen will assist in the Program of Study in Public Health Nursing, especially as it relates to industrial nursing. All her friends at headquarters and throughout the states where she has traveled this past year will miss Heide Henriksen's humor and radiant good spirits as well as her professional skill always so generously offered to all who asked.

Ruth M. Scott, former consultant public health nurse and industrial nursing consultant of the Indiana State Board of Health, Division of Public Health Nursing, joins the staff in October, replacing Miss Henriksen. Other experience of Miss Scott includes school nursing in Fort Wayne, Indiana, and Salem, Ohio; industrial nursing, Jamestown, New York; obstetrical nursing at Sturgis Memorial Hospital, Sturgis, Michigan; county public health nursing under the Children's Fund of Michigan. She is a graduate of the Lutheran Hospital School of Nursing, Fort Wayne, Indiana, and holds a B.S. degree in nursing education, with a major in public health nursing, from Indiana University.

CCC TO RELEASE RETIREMENT PLAN

Early in 1945 the Community Chests and Councils will release a national retirement plan for employees of welfare and health agencies. The organization through which the plan will function is the National Health and Welfare Retirement Association, and insurance will be provided by the John Hancock Mutual Life Insurance Company. NOPHN member agencies as well as other nursing organizations will be eligible to enroll and should consult their local community chests about the plan. Further information will be published as soon as it is available.

AWCS PROJECT

New visiting nurse services have already been established in two towns as the direct result of visits made to many southern communities since the first of the year by Ruth Fisher and Dorothy Rusby, who were assigned from the NOPHN staff to its American War-Community Services project. AWCS offers advisory service in war areas regarding the establishment of nursing care of the sick and of maternity patients in their homes as part of a general community public health nursing service. Assistance of various types has been given in all of the war-expanded communities visited, and in addition to the two completed visiting nurse services, at least three other communities are in the beginning stages of organization. AWCS has given assistance not only in the principles of organization for both public and private agencies, but also in the interpretation of new programs to physicians, nurses, and board members.

NOPHN hopes soon to open a regional office

in Atlanta, Georgia, and plans are being made to enlarge the national field staff.

Because workers are sorely needed for the local areas . . . 600 U. S. communities of 10,000 population have no form of public health nursing care of the sick at home . . . qualified nurses interested in serving the war communities are asked to get in touch with Miss Fisher, director of the project, at NOPHN headquarters. To assist in bringing the need for workers before the general public NOPHN has published a new folder entitled "Visiting Nurse—A Community Asset," copies of which are available free in any quantity upon request. Another folder, "United for Country and Community," explaining the work of the AWCS in general, has been prepared by the six agencies constituting the Service, and copies are available free at NOPHN.

TUBERCULOSIS NURSING PROGRAM

The nursing program of the recently established Tuberculosis Control Division of the U. S. Public Health Service is getting under way. Public Health Service Consultant Margaret S. Taylor (formerly the public health nursing consultant in Public Health Service District IX) is in charge of the tuberculosis nursing program. Nine additional nurses have been assigned to this program. Five of these were already employed by the Public Health Service but had been assigned to the Emergency Health and Sanitation program.

During the first two weeks of September all of the nurses assigned to the Tuberculosis Control Division attended an orientation program at Bethesda which was conducted by the staff of the Tuberculosis Control Division with the assistance of Mrs. Louise Lincoln Cady, tuberculosis nursing consultant for the NOPHN, Ruth Farmer and Isabelle Ryer, tuberculosis nursing supervisors from the Detroit City Health Department.

Dr. Herman E. Hilleboe, director of the Division, has requested the NOPHN to define the functions of the public health nurse in tuberculosis control. A committee met August 30 and a tentative outline has been prepared.

Dr. Hilleboe has also asked the NOPHN to consider what should be the preparation of a consultant in tuberculosis nursing. A committee has met to outline prerequisites for the student in such a program and make suggestions for the theory and experience required in the course. Reports of these committees will be submitted to the Education Committee and Collegiate Councils on November 3.

All of the tuberculosis nursing personnel will be initiated into the Public Health Service program through assignments to the mobile X-ray units which heretofore have operated without nursing assistance. The nurses assigned to these units will assist in implementing the follow-up program in the community (following the mass X-rays) and will be available to assist local nursing groups with staff education programs in tuberculosis. Later, a number of the nursing consultants will be available for assignment to state health departments to help in the development of state tuberculosis programs.

NOPHN AT CONFERENCE ON INTERNATIONAL AFFAIRS

Through its representative, Pearl McIver, chief, Office of Public Health Nursing, USPHS, NOPHN on July 28 participated in the second program of the Women's Conference on International Affairs which was devoted to consideration of the work of the United Nations Interim Commission on Food and Agriculture. Over 50 national women's organizations are now identified with this program, which is designed to stimulate interest in the problems related to foreign policy.

The Interim Commission was appointed in July 1943 to prepare a specific plan for a permanent international organization for food and agriculture as recommended by the Hot Springs Conference in June 1943. The permanent international body—to be known as the Food and Agriculture Organization of the United Nations—will come into being when 20 nations have accepted the constitution. The Organization will have permanent responsibilities in relation to long-term problems throughout the world, and its broad objectives as set forth in the Preamble to the Constitution are: (1) to raise levels of nutrition and standards of living among the peoples of the world (2) to secure improvements in the efficiency of the production and distribution of all food and agricultural products (3) to better the condition of rural populations, and (4) to contribute by these means toward an expanding world economy.

A third program of the Women's Conference on International Affairs on September 21 will deal with proposals formulated at the Interna-

tional Monetary and Financial Conference at Bretton Woods.

The first program on May 6 included reports of returned delegates to the Conference of Allied Ministers of Education in London.

ORTHOPEDIC SCHOLARSHIPS

A meeting will be held November 13 to award NOPHN orthopedic scholarships offered by the Joint Orthopedic Nursing Advisory Service through a grant from the National Foundation for Infantile Paralysis. Purposes of the scholarships, granted on a competitive basis, are to prepare nurses for orthopedic teaching positions in universities or in clinical practice fields used for teaching purposes, and to prepare orthopedic supervisors for public health nursing agencies. Final date for filing applications was October 1.

The scholarships cover tuition, paid directly to the university, traveling expenses to and from the city in which the university is located, and a monthly stipend for living expenses. The total amount depends upon the length of the program of study, not to exceed one year. The program for which an award is made depends upon the type of preparation which the nurse needs to meet NOPHN qualifications for supervisors or consultants in special field. Awards may be made for a program of study to complete requirements for a baccalaureate or master's degree, an approved course in physical therapy, or the approved program of study in public health nursing.

NOPHN HONOR ROLL

Agencies reporting 100 percent staff enrollment in the NOPHN totalled 800 October 1st. The 1944 record threatens to fall below that of 1943 unless more agencies join the list. Remember that to be on the Honor Roll agencies must have all *permanent* members of the staff enrolled as NOPHN members.

FLORIDA
Jacksonville—Duval County Health Unit

ILLINOIS
*Evanston—Evanston Infant Welfare Society
*Evanston—Visiting Nurse Association

KANSAS
Kansas City—Visiting Nurse Association

KENTUCKY
Pineville—Bell County Health Department

MICHIGAN
*Grand Haven—Ottawa County Health Department

MINNESOTA
Crosby—School Nursing Service
*Hallock—Kittson County Nursing Service
St. Paul—Bureau for Crippled Children
Waseca—School Nursing Service
Winona—School Nursing Service, Teachers College

MISSOURI
Fayette—Howard County Nursing Service

NEW JERSEY
*Montclair—Bureau of Public Health Nursing
*Orange—Visiting Nurse Association of the Oranges and Maplewood

NEW MEXICO
Santa Fe—Division of Crippled Children, State Department of Public Welfare

OREGON
*Astoria—Clatsop County Health Department
*The Dalles—Wasco-Sherman Health Department

PENNSYLVANIA
Lycoming County—Pennsylvania State Nursing Service

RHODE ISLAND
*Woonsocket—Public Health Nursing Association

TEXAS
*Sierra Blanca—Hudspeth County Nursing Service

VERMONT
Waterbury—Public Health Association

WISCONSIN
*La Crosse—City Health Department
Milwaukee—Fox Point Health Department

WYOMING
Albany County—Department of Public Health

ALASKA
Nome—Nome Department of Health

*On Honor Roll for 5 years or more.

NOPHN FIELD SCHEDULE

Staff Member	*Place and Date*
Mary C. Connor	Orange, New Jersey—October
Ella Louise Gilmore	Meriden, Connecticut—October
Hortense Hilbert	Montclair, New Jersey—October 16-20
Louise Lincoln	Santa Fe, New Mexico—November 8-9
	Dayton Ohio—November 13-14
	South Bend, Indiana—November 15-16
	Lansing, Michigan—November 17-18
Bosse B. Randle	Boston, Massachusetts—October 19
Jessie L. Stevenson	Durham, No. Carolina—October 23
	Charlotte, North Carolina—October 25
	Hutchinson, Kansas—October 28
	Chicago, Illinois—October 30-Nov. 1

In addition to the visits scheduled, on September 21 Miss Gilmore participated in a conference sponsored by the ANA on counseling and placement of nurses released from military service.

NEWS AND VIEWS

Highlights on Wartime Nursing

INTENSIVE SHORT COURSES

A nationwide plan has been effected whereby acute shortages in essential nursing positions will be relieved by a program of intensive short courses. This emergency measure inaugurated by the Division of Nurse Education of the U. S. Public Health Service, in conjunction with state boards of nurse examiners, state departments of public health, and other interested groups, will be financed by federal funds.

According to a recent survey made by state health departments and the U. S. Public Health Service, an alarming number of shortages exist in the public health field alone. In order to attain even the minimum ratio of 1 staff nurse to every 5,000 population, there is need for approximately 8,000 additional public health staff nurses. Likewise, if the ratio of 1 supervisor to 9 staff nurses is to be realized, 968 new supervisors must be made available.

Schools of nursing faced with larger enrollments report critical shortages in instructional, supervisory, and administrative nursing fields.

To help meet these demands quickly, the new intensive short courses will be functional rather than academic in nature. They are designed to give immediate aid to instructors and supervisors, head nurses, administrative and other teaching and supervisory personnel in greatest need of preparation.

Lucile Petry, director of the Division of Nurse Education, has stressed the fact that intensive short courses will not supplant well-established or modified programs now being conducted in recognized universities. It is hoped, rather, that enrollment in the latter will be increased through added impetus given them by this plan.

Federal funds through the Bolton Act will cover the instructional cost fee for each graduate nurse who enrolls, and the maintenance fee in cases where the course requires a nurse to be away from her usual residence for brief periods of time.

In order to conduct this program, additional instructors or "trainers" must be made available. Consequently, the first step in the new plan will be a series of intensive courses to prepare special "trainers." These will begin this month in 12 of the Nation's largest university centers and will continue throughout the year in these and other centers. By this method, it is expected that at least 400 graduate nurses will receive preparation as "trainers" during the coming year.

Universities conducting the initial "trainer" courses are: University of California; University of Colorado; Catholic University of America; University of Chicago; St. Louis University; Teachers College, Columbia University; University of Pittsburgh; Western Reserve University; University of Washington; Boston University; University of Minnesota, and Vanderbilt University.

Upon the completion of their special preparation, the "trainers" will return to designated areas and conduct one or more of the following types of intensive short courses: extra-mural; condensed; or a course by a circulating teacher. These types are described in brief.

Extra-mural courses will be conducted in centers where graduate nurses from several institutions come together once a week or oftener for a period of from 6 to 16 weeks.

Condensed courses will be conducted in a university or local center for from 1 to 6 weeks of full-time, concentrated study.

Courses taught by a circulating teacher are designed for those nurses who may not be able to obtain brief leaves of absence. The circulating teacher will spend one half to three days in an institution or agency, or in a combination of adjacent institutions, and will circulate to other institutions.

By the end of the year, it is hoped that at least 5,000 graduate nurses will have received special preparation for their specific positions through this new program.

State directors of public health nursing will

Presidents of national nursing organizations are among the members of the National Nursing Planning Committee of the National Nursing Council for War Service, which met September 12 (page 497). Left to right (seated) Marjorie B. Davis, secretary of the Committee; Katharine J. Densford, president, ANA; Stella Goostray, chairman, NNCWS; Mrs. Frances F. Gaines, president, NACGN. Standing: Ruth Sleeper, president, NLNE; Marion W. Sheahan, president, NOPHN and chairman of the Planning Committee.

work directly with state boards of nurse examiners both for the recruitment of "trainers" and enrollees. It is hoped that close cooperation between administrators in the field of public health nursing and schools of nursing, hospitals and nursing personnel who have been provided with data regarding the program, will result in determining vital needs to be met, and increasing the pool of nursepower.

COLLEGE COUNSELING PROGRAM

Leading educators and members of the nursing profession were scheduled to speak at an orientation institute held in New York September 27-30 for the college counseling staff, established for a second year under the joint auspices of the National Nursing Council for War Service and the U. S. Cadet Nurse Corps.

These 17 young women, all college graduates and some holding advanced degrees, are on short-term leaves from positions of responsibility in leading schools of nursing, in hospitals, visiting nurse associations, and public health staffs. In some 400 universities, colleges, and junior colleges they will bring home to undergraduate audiences the urgent need for more and better qualified nurses, not only for the duration but also for postwar health programs now in the making. They will also act as counselors or consultants to college administrators, faculty members and vocational guidance personnel, informing them of the latest developments in nursing education, greatly stimulated by the war, and of the expanding opportunities in nursing for women with special preparation.

Members of the 1944 college counseling staff appointed to date include the following from the public health field: Mrs. Carolyn Crosby, former member of the Harlem Hospital nursing staff and of the Detroit Visiting Nurse Association; Eugenie de Armit, district supervisor, Visiting Nurse Association of Boston; Alice Marcella Fay, assistant professor of public health nursing, Incarnate Word College, San Antonio, Texas; Mrs. Thelma M. Hoff, former senior supervisory counselor of the Hillsdale County Health Department, Hillsdale, Michigan; Elizabeth Howland, assistant director, Visiting Nurse Association of Boston; Elisabeth C. Phillips, assistant director, Visiting Nurse Service of New York; Julia Dupuy Smith, director, Instructive Visiting Nurse Association,

Richmond, Virginia; Mrs. Mary Taylor Swoboda, mental hygiene consultant, Springfield (Massachusetts) Visiting Nurse Association and lecturer in mental hygiene in nursing at Boston University; Lucy Gordon White, supervisor, Visiting Nurse Service of New York.

RECRUITMENT NOTES

Rotary clubs throughout the country have requested suggestions as to how they can participate in the U. S. Cadet Nurse Corps recruitment program. In response, the National Nursing Council and the USPHS are suggesting a nationwide plan whereby state nursing councils may make use of Rotary assistance in recruitment programs. A special kit of procedures, information, and publicity has been compiled for Rotary clubs. The plan calls for close cooperation of clubs with state and local councils—Rotary to clear plans with nursing councils, nursing councils to supply information and help to Rotary.

Field workers of the Public Relations Section, Division of Nurse Education, USPHS, have been appointed in four districts—Washington, D.C., New York City, San Francisco, New Orleans. Each serves surrounding states. Official appointments for other districts have not yet been announced. The duties of these recruitment and public relations representatives include the planning of publicity, furthering relations with the press and radio, Office of War Information and civic organizations in promoting the recruitment campaign of the Cadet Nurse Corps. They will work closely with the state recruitment committees of the nursing councils, hospitals, schools of nursing and with local units of the Cadet Nurse Corps. They may be consulted on nursing publicity programs that promote student recruitment.

A striking new recruiting poster for the U. S. Cadet Nurse Corps, "Be a Cadet Nurse—the Girl with a Future," will go up all over the country this month. The model is Cadet Nurse Beulah Tyler, a junior cadet at Alexandria Hospital School of Nursing, Alexandria, Virginia. Jon Whitcomb, famous national magazine cover artist, now a lieutenant in the U. S. Naval Reserve, did the art work. Final touches were added the day he left for duty as a combat officer in the South Pacific.

In a recent release by the War Manpower Commission, it is stated that persons engaged in essential and locally needed activities who wish to leave their employment to accept training in the U. S. Cadet Nurse Corps must first obtain a certificate of availability or be referred by the U. S. Employment Service. If an unfavorable reply is received from both employer and USES the applicant may appeal in turn to the Area and Regional Management-Labor Committees and last to the chairman of the War Manpower Commission at Washington.

A movie "Reward Unlimited" and a playlet "This Is Our War" are available for community use to stimulate recruitment. Information about them can be obtained from state nursing councils.

CLASSIFICATION OF SENIOR CADETS

The Nursing Section of Procurement and Assignment Service, War Manpower Commission, has recommended that state and local P and AS committees begin immediately to classify senior student nurses, including senior cadets, to determine in advance how many nurses will be available for military service and for essential civilian nursing. The Division of Nurse Education, USPHS, is cooperating in the plan. Senior students will be classified within three months before graduation.

Directors of schools of nursing will be asked to furnish local P and AS committees with lists of senior students, expected date of graduation and address at which each can be reached during the last three months of her basic nursing program.

Local procurement and assignment committees have been instructed to classify as "available for military service" senior students who state that they (1) intend to enter military service (2) expect to enter fields not recommended for new graduates because of wartime shortages in more vital nursing services—private duty, office nursing, specialized public health nursing, etc., and (3) have not made plans for work after graduation.

Senior students will be classified tentatively as "essential for civilian nursing service" if they (1) plan to enter an essential field of nursing in a civilian or non-military government agency known by Procurement and Assignment to need additional nursing service or (2) have been selected for and propose to take postgraduate

work to prepare for essential nursing positions. This group will be reclassified after graduate positions have been accepted.

Procurement and Assignment Service and the Division of Nurse Education have estimated jointly that the following distribution of student nurses graduating this year must be made in order to meet both military and essential civilian needs: one third should enter the Army or the Navy Nurse Corps; 50 percent should fill immediately essential nursing positions not requiring postgraduate preparation; and 15 percent should undertake postgraduate study, if qualified, to prepare for positions in schools of nursing, hospitals, and public health which require additional preparation. Classification of senior students will determine in advance the approximate number of young graduates who will be available for each type of service.

"COMBINED OPERATIONS"

Procurement and Assignment Service and the National Nursing Council for War Service are cooperating in a "combined operations" campaign in support of the Army and Red Cross drive to recruit 4,000 Army nurses during the early Fall.

An extensive publicity program has been planned. Nursing councils are coordinating local drives with the national campaign. The Red Cross has obtained radio time in five cities where there are many nurses, and is also sponsoring advertisements and distributing posters to encourage recruiting. *Combined Operations*, a bulletin of campaign reports and suggestions, is being issued at intervals by the NNCWS to state and local councils, state and local Procurement and Assignment Service committees and Red Cross recruitment committees.

P and AS committees have been asked to act promptly on requests for classification and reclassification of nurses who respond to the Army appeal.

All but two states now classifying nurses have forwarded lists of nurses in Class I to the Central Office for mailing to the Army. From these lists the names and addresses of nurses in Class 1A have been made available to the Navy.

COST STUDY

A study of the actual cost of nurse education will be made by the Division of Nurse Education, USPHS, this fall in some 50 representative schools of nursing throughout the country, Surgeon General Thomas Parran, USPHS, has announced. The information thus obtained will be useful as a guide in the operation of the U. S. cadet nurse program and to the schools and hospitals in planning their programs. Dr. Louis Block, cost analyst, will conduct the study.

From Far and Near

● Lois Olmsted on August 1 assumed her duties as consultant in orthopedic nursing for the National League of Nursing Education, having been appointed to replace Carmelita Calderwood who resigned to return to Iowa after having held the position since 1941. For the past year Miss Olmsted had been instructor and clinical supervisor of orthopedic nursing at the Good Samaritan Hospital, Portland, Oregon. Previously she had taught nursing arts in the Cook County School of Nursing, Chicago, and the Ellis Hospital, Schenectady, New York, and had done orthopedic nursing with the Chicago Visiting Nurse Association. She is a graduate of the Cook County School of Nursing, holds a master of science degree in nursing from Western Reserve University, Cleveland, and is a graduate of the physiotherapy course at Northwestern University, Chicago.

● Mrs. Maria Larossa, Red Cross scholarship student from Caracas, Venezuela, returned in September to the Venezuela Red Cross School of Nursing. After studying at Western Reserve School of Nursing Mrs. Larossa spent her last three months in this country visiting district nursing associations and studying at Vanderbilt University.

● Four appointments have been announced for the Red Cross Nursing Service:

Ruth Addams succeeds Mrs. Gertrude Lyons as director of nursing service, North Atlantic Area; Mary Elizabeth MacLaren is new deputy director. Ann K. Magnussen succeeds Miss Addams as director, Southeastern Area. Elizabeth Diehl is the newly appointed deputy director for the area.

(Continued on page A19)

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